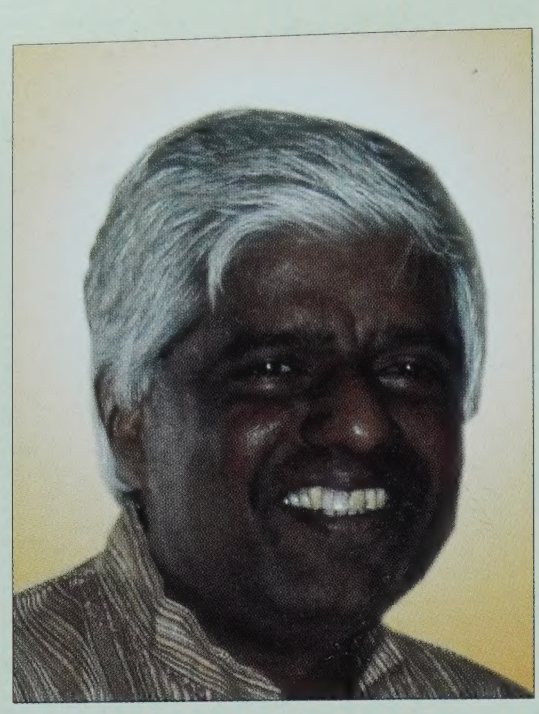
GENDER PERCEPTIONS OF FAMILIES AND COMMUNITIES

IN COMMUNITY MENTAL HEALTH
&
DEVELOPMENT PROGRAMMES

A Report on the Study
in Lohardaga District of Jharkhand &
Gaya District of Bihar
by

Basic Needs India
in partnership with
Nav Bharat Jagriti Kendra



Shri D.M. Naidu

A Founder Trustee of Basic Needs India

This study report is dedicated to Shri Naidu who passed away on 15th March 2011.

He was very concerned that the poor and persons with mental illness should benefit from the programmes implemented for them. He was the prime initiator of this study on gender preceptions.

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The woman on the cover with goats is Lilawathi Devi, a person with mental illness from Sultana panchayat of Katkamdag Block, Jharkhand

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Gaya District of Bihar

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For CLIC
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PREFACE

There was a big disparity in the number of women with mental illness identified and being taken for treatment in the Community Mental Health Programme that was implemented by Basic Needs India in partnership with Nav Bharat Jagriti Kendra (NBJK) in Bihar and Jharkhand. More men and less number of women with mental illness were identified and coming for treatment. This was a matter of concern for both organisations and they wanted to find out the reasons for this disparity.

A study on this was conceived and a plan was made in June-July 2005 under the guidance of Dr L.S Saraswathi, a researcher and Advisor to Basic Needs India. A workshop on Gender and related issues for three days was held in Ranchi in October 2006 for all the NGO partners of NBJK. This was followed by several meetings and discussions, and by mid-2007, identification of population and sample, decisions on the methods of interviewing and focus group discussions (FGD's), preparation of interview schedule for the Heads of Households, with persons with mental illness and family members and guidelines for all these were completed. BNI is thankful to Mr. Naidu and Ms Valli Seshan for their participation and valuable suggestions to this process and their inputs in the meetings that were held at the planning and implementation stage of the study.

Hiring of investigators and working out the logistics in the field for collection of data were completed by end of 2007. The data collection, checking the collected data, revisiting the field for gaps to be filled in and entering the data into computer were done by June 2008.

A statistician from Loyola College, Chennai was consulted for analysis of data, which was completed by end of July 2008. Organizing the data, selection of the kind of data to be presented in the report took few months. The first draft of the report came out in May 2010. This required extensive revision and thanks to Dr Saraswathi for her meticulous work in going through the draft report and for her comments, observations and suggestions for improvement.

This report has two sections, the first on gender and related issues from review of literature. The second section includes the findings from the data collected from the two districts. The report is descriptive of the study process, the findings and it makes recommendations for the two organisations for follow up. This study is valuable for those interested to learn about the gender issues on the whole, and in Bihar and Jharkhand in particular.

FOREWORD

Community surveys of mental health and mental disorders from world over, including India, show that women report significantly higher levels of emotional distress. Emotional distress in women in low income countries such as India manifest in a variety of ways which include presentation with predominantly bodily complaints (somatic symptoms) and presentation with various types of physical ill health.

It is widely accepted that emotional well being or distress of women in India is closely linked to their overall social situation, status and a variety of local, economic and cultural factors. Cumulative and interrelated life events and stressors of various types also contribute to chronic emotional distress. A steadily worsening sex ratio and an ever growing violence against women exemplify the continuing gender based discrimination and problems that confront women in India. A recent United Nations study has revealed that India has the world's worst gender disparity in child mortality.

Basic Needs India (BNI) in partnership with Nav Bharat Jagriti Kendra (NBJK) has conducted Community Mental Health and Development (CMHD) programmes in the states of Bihar and Jharkhand two of the most backward states in India, (as also several other states) with a vision of providing treatment access to persons with mental illness (PwMI) in rural areas and bringing them and their families into the process of development. In their CMHD programmes in Bihar and Jharkhand, BNI found that males far outnumbered females in accessing treatment as well as participating in their services. BNI also observed such a gender disparity in the staffing pattern of their partner organizations. The study reported in this publication is the outcome of BNI's enquiry into the reasons for the under representation of women in their programme and the "mental health gender gap" in rural Bihar and Jharkhand.

Although there are several studies which have explored various aspects related to women's mental health in India, the "real world" ground realities of mental health and ill health of rural women in backward states such as Bihar and Jharkhand are not well understood. The descriptive study reported in this publication, conducted in Gaya district of Bihar and Lohardaga district of Jharkhand by detailed interviews of heads of families of PwMI and focus group discussions, profiles in detail, persons with mental illness in both the districts and provides gender perceptions of families and communities involved in the programme in both the districts.

The results are important as majority of the population studied belong to the scheduled castes, scheduled tribes and backward classes. It is clearly established that in both the districts (with few distinct differences) whether well or ill, women have a "lower and secondary" status and one of the primary tasks expected of them is "reproduction", while men remain the final decision makers even in matters concerning women. However, when family planning is considered, it is widely held that women rather than men should undergo family planning surgery.

The publication has an informative section of review of relevant literature which covers important issues such as gender specific risk factors for developing emotional problems, issue of giving and receiving dowry, preference for male child and its consequences, low age at marriage, female foeticide and domestic violence. Based on the results, the study makes several 'do-able' recommendations to BNI, NBJK, their NGO partners and the community at large, towards achieving gender equity at all levels. This report is an important addition to the literature on rural mental health and will be of interest to all those who are involved in community mental health in India.

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Nav Bharat Jagriti Kendra (NBJK)

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- ✓ Mr. Bhaskar Chakraborty, Mental Health Programme Coordinator
- ✓ Mr. Mohammad Shamaun, Mental Health Programme Coordinator

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Basic Needs India

Basic Needs India (BNI) was established in 1999 with a Mission to actively involve persons with mental illness and their care givers to enable them to meet their basic needs and to ensure that their basic rights are respected and fulfilled. In doing so, to stimulate and work in partnership with other organizations that promote the cause and influence public policy on mental health issues.

BNI's Community Mental Health and Development (CMHD) Approach has strong focus on poor persons with mental illness in rural areas. It has five components:

- **Community Mental Health**: Brings easy to access and cost effective treatment to people, especially from the Govt. system.
- **Capacity Building**: Sensitizes and develops the ability of health personnel, communities and persons with mental illness themselves and family members to deliver comprehensive support to the lives of persons with mental illness.
- **Sustainable livelihood**: Enables persons with mental illness and their family members to get involved in economically viable activities, including returning to their earlier occupation.
- **Research, policy and advocacy**: Involves generating data and evidences from programmes for influencing change in policies and procedures and for advocacy work.
- **Administration & Management**: Develops systems in the organization to ensure the quality of programmes and optimum use of resources.

These components aim to strengthen persons with mental illness and their families to be self reliant, free of stigma and to facilitate access to public provisioning systems, namely health care and social security entitlements.

BNI's main role is that of a resource organization that works with partner organizations to implement programmes to create a caring, accommodating and understanding environment to ensure service provision, social inclusion and the right to equal opportunities for persons with mental illness and their families.

Presently BNI is working with partners in the States of Andhra Pradesh, Karnataka, Tamil Nadu, Kerala, Odisha and Maharashtra. Through this work, till date, lives of 19,000 persons with mental illness and their families have been touched.

Basic Needs India is a registered Trust under the Indian Trust Act with a Board of seven trustees.

Nav Bhârat Jagriti Kendra

Nav Bharat Jagriti Kendra (NBJK) was established in 1971 by four engineering graduates influenced by the ideology of Mahatma Gandhi, with a vision that no one remains hungry, unemployed, illiterate, exploited and discriminated. Towards achieving this vision, NBJK has been working to educate, organize and empower the rural poor for achieving social justice, economic growth and self-reliance

NBJK has adopted an integrated approach for rural & urban development. The operational areas of NBJK are 18 districts in Jharkhand and 22 districts in Bihar, working directly and through a network of partner organisations. They are working on the issues of education, health, livelihood and rural entrepreneurship, advocacy, networking and support to small local voluntary organizations.

Activities of NBJK include

- Community Based Rehabilitation (CBR) for persons with disabilities
- Community Mental Health Program.
- Adolescent sexual and & reproductive health
- Rural health camps in remote villages
- Micro Finance with about 30,000 women of SHGs (Self-Help-Group) & men of Joint Liability Groups
- Watershed management program in 3 blocks
- Employability Training Centers for 5000 rural youths in 5 districts
- Skills training and seed capital for self-employment to persons with disabilities and Stabilized mentally ill persons
- Manav Jodo Abhiyan- promoting inter-caste/inter-religion/ love marriages without dowry - based on gender equity.
- Promoting women's leadership and candidature in local governance

The Community Mental Health and convergence of Services Program was started in the year 2002 with the support of Basic Needs India. NBJK implemented this programme through 25 partners organizations spread across 32 blocks and 15 districts in Bihar and Jharkhand.

The presence and work of NBJK in 40 districts for over 40 years and good relationship with the people has established the organization on a stable ground with good reputation and support for the sustainability of its programs.

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Partnership between Basic Needs India and NBJK

Nav Bharat Jagriti Kendra (NBJK) has been working in the field of socio-economic development since 1971 in the rural areas of Bihar and Jharkhand. The programmes implemented with support from many local partners and voluntary organizations cater to the needs and development of 2.1 million people in those two States.

Basic Needs India entered into partnership with NBJK in the year 2002 for the programmme on Community Mental health and convergence of Services in the two states. This programme was implemented through 25 partners of NBJK across Bihar and Jharkhand spread over 32 blocks and 15 districts.

The objectives of the programme were to assist persons with mental illness to access medical services through the government hospitals where available, and through the medical camps conducted every month by NBJK where such services from hospitals were not available.

Awareness and training was given to the staff of partner organizations on mental illnesses, on caring for persons with mental illness and other related issues. This training enabled them to identify persons with mental illness and to bring them for treatment and follow up support.

Caregivers associations were formed and awareness on mental health issues were given to them. The members of this association supported and followed up on the needs of persons with mental illness and their families.

As a source of income is always considered an important and basic requirement, support for livelihood and income generation activities were given directly and through linkage with banks and financial institutions to persons with mental illness and to their family members.

Support and training to the staff of NBJK and their partner organizations were given on data collection, documentation, field visits, case study preparation and for effective management of the programme.

This study was conducted by Dr. Janardhana and Subrat Kumar Mishra, who guided and assisted the workers of NBJK and of the local organizations to collect the data and to tabulate them.

Dr. L.S. Saraswathi, an Educationist and a Researcher from Chennai, guided the process and authored this study in consultation all stateholders.

INTRODUCTION

"Men and women are born of woman; before all else we are our mother's child. Yet all our desires seem designed to deny this fact..... the myth of genesis seems to express..... Man is born of God, an idealized paternal figure.....and Woman is born from Man's body"

Chasseguet-Smirgel.J.

The term *gender* is often used to classify the anatomy of a person's reproductive system as a male or a female. In social sciences however, the concept of gender means much more than biological sex. It refers to the socially constructed expectations regarding the ways in which one should think and behave, depending on the sexual classification. These stereotypical expectations are commonly referred to as gender roles. The 'family' is central to the thinking of gender discrimination. It mediates the values in the wider culture in which it is embedded. Children first learn what it means to be a male or a female most often in the family context, the same being influenced throughout their lives. Attitudes toward gender roles are thought to result from complex interactions among societal, cultural, familial, religious, ethnic and political influences. The already existing gender discrimination in society influences the care services and outcome for people with mental illness in their families and in communities.

The biological difference seemed to have paved way to a system of patriarchy, male superiority and dominance that has increased the differences between man and woman, which has become apparent and permeated all aspects of living. Hence, today, we experience differences between man's and woman's way of perceiving, feeling, thinking, analyzing, reacting, expressions of emotions, caring, and coping with difficulties. Traditional gender roles define masculinity as having power and being in control in emotional situations, in the workplace and in sexual relationships. Acceptable male behaviors include competitiveness, independence, assertiveness, ambition, confidence, toughness, anger and even violence, to varying degrees.

Gender affects many aspects of life including access to resources, methods of coping with stress, styles of interacting with others, self-evaluation, spirituality and expectations of others. These are all factors that can influence mental health either positively or negatively. The expectations of families and the communities would determine the outcome expected. Gender studies seek to understand better the relationship between gender and mental health in order to reduce the risk factors and improve treatment methods.

Traditionally, 'femininity' is defined as being nurturing, supportive and assigning high priority to one's relationships. Women are expected to be emotionally expressive, dependent, passive, cooperative, warm and accepting the subordinate status in marriage and employment. Division of labor by sex in the society ensures that the family is the major beneficiary of women's labor and acts as a major source of women's identity. Socially constructed gender roles make women the principal care-givers in many settings, while giving them less social support to perform this function, leading to low morale and high stress levels. Being passive and patient by nature, women are expected and are unconsciously assigned the role of care-giving to persons with illness in their homes.

From a review of literature on Gender and mental health, it is evident that depression, anxiety, psychological distress, sexual violence, domestic violence and escalating rate of substance use affect women to a greater extent than men across different countries and different settings. Pressures created by their multiple roles, gender discrimination and associated factors of poverty, hunger, malnutrition, over work; domestic violence and sexual abuse combine to account for women's poor mental health. However, the data of the Community Mental Health and Development (CMHD) program of Basic Needs India (BNI) in Bihar and Jharkhand revealed that men approached mental health camps more in number when compared to women. In the CMHD Program of BNI, gender balance is focused and efforts are made towards the same, starting with identification of illness to rehabilitation, ensuring equal participation of men and women under this program. Participation of women that remained low is being energized to bring them in to this program.

Need for the Study

In the project area of Basic Needs India and NBJK in Bihar and Jharkhand, the available information on persons with mental illness (PwMI) indicates a gender disparity, in favour of men. Right from identification of PwMI to those under treatment; from stabilization to being part of rehabilitation, men outnumber women. Though the statistics world over states that there is an equal number of men and women affected by mental illness, the ratio of men and women in the project area varied from 90:10 to 52:48. This disparity has been observed within the partner organizations too as far as staff employment pattern is concerned. Under these circumstances, it was considered useful to determine the reasons for the existing situation so that actions could be taken to overcome the incongruity that exists.

The quarterly and annual reviews and midterm evaluation carried out in the first five years of the project period showed vast differences in the participation of men and women with mental illness in the program. This led to the recommendation to do a research study in order to understand the reasons for under representation of women in the program. It was felt that this could help to understand the gender issues in the communities in general and to understand the status of women in these communities. In both the states, demographic characteristics reveal that a sizeable population is tribal, hence there is a need for understanding the tribal and non-tribal cultural beliefs and practices in determining the gender issues. The following questions were considered as the base for our search to understand the reasons for such incongruity:

1. Why women with mental illness appear to be less in number?
2. Why women with mental illness are not referred to or taken for treatment?
3. What is the status of women in the tribal as well as non-tribal communities in Bihar and Jharkhand?
4. What are the socio cultural beliefs and practices contributing to women's under representation?

CHAPTER 1 : REVIEW OF LITERATURE

I. Development of Sex-role Identity

Development of the sense of self or identity begins around 7 or 8 months of age and continues to develop over the life time of the person. One's feeling of identity – of personhood is composed of physical, psychological, social and cultural elements.

An extremely important part of one's identity, one that begins at birth is one's self-identification as either a male or a female. It is thought that identification in terms of sex begins at 18 months of age and it is clearly internalized by the age of three. However, sexual identity is more complex than simply 'knowing' that one is a male or a female. More important to sense of self is one's identification as a member of a **gender group** – "I am a girl", "I am a boy". While sex is a biological characteristic, gender is a social one. In all cultural groups, gender identity includes knowledge of the set of rules and expectations governing what boys and girls should wear, how boys and girls should act and express themselves, and the 'place' of boys and girls or men and women in the overall structure of the society. Knowledge of these rules is knowledge of one's role as a member of a gender group.

Primary socialization and sex-role learning usually occurs in the family through close relationship with parents, other adult relatives, siblings and playmates. The rules associated with one's sex-role may vary by race, ethnicity, social class, religion and even by geographical region. This socialization takes place in a variety of ways, many of them small and incremental – simple routines of daily life and language. The process of sex–role learning has three parts (1) The child learns to distinguish between men and women, between boys and girls, and to know the kind of behavior that are characteristic of each. (2) The child learns to express appropriate sex role preferences for himself or herself. (3) The child learns to behave in accordance with sex role standards. (Cushner, Kenneth H. p.193 – 194)

II. Understanding 'Gender'

The distinction between sex and gender is the subject of much discussion. These need to be clearly defined. Some important terms used in the study of "Gender" are:

Sex: "Sex is the biological difference between men and women. Sex differences are concerned with men's and women's bodies. Men produce sperm; women bear and breastfeed children. Sexual differences are the same throughout the human race".

Gender: "Sex is a fact of human biology; gender is not. The experience of being male or female differs dramatically from culture to culture. The concept of gender is used by sociologist to describe all the socially given attributes, roles, activities and responsibilities connected to being a male or a female in a given society. Our gender identity determines how we are perceived and how we are expected to think and act as women and men because of the way the society is organized".

Gender relations: "These are social relationships between men as a sex and women as a sex. Gender relationships are simultaneous relations of cooperation, connection, mutual

support and of conflict, separation and competition of differences and inequality. Gender relations are concerned with how power is distributed between the sexes. They create and reproduce systemic differences in men and women's position in a given society. They define the way in which responsibilities and claims are allocated and the way in which each is given a value. Gender relations vary according to time and place, and between different groups of people. They also vary according to other social relations such as class, race, ethnicity, disability and so on."

Gender analysis: "Such an analysis explores and highlights the relationships of men and women in society, and the inequalities in those relationships by asking: Who does what? Who has what? Who decides? How? Who gains? Who loses? When we pose these questions we also ask which men and which women? Gender analysis breaks down the divide between the private sphere (involving personal relationships) and public sphere which deals with relationships in the wider society." (March, Candida. Smyth, Ines and Mukhopadyay Maitrayee pp. 17-18).

Sex-roles are normative – that is, the ideas about what attitudes, values and behaviour are associated with one's **gender** have been coded by the social group into **norms or stereotypes.** A norm is a rule of conduct based on attitudes and values which are usually internalized through socialization. Because these norms are so much part of us, they seem '**natural' and 'right'** and we take them very much for granted. That sense of '**naturalness'** is probably the most powerful force operating to encourage obedience to norms. In all societies, there are sanctions or punishments, for deviation from such norms.

Sex-role stereotypes have particular content. In every society stereotypic content is **differently valued.** Not only are boys and men perceived to be different from girls and women, their behaviour is also highly valued. Sex stereotypes '**genderize'** traits which either males or females are able to display in favour of one gender or the other (Cushner, Kenneth H. pp.197,198)

A distinction between sex-role stereotyping, sex bias and sex discrimination has been made by Carelli, (as quoted by Cushner, Kenneth H. p199)

"Whenever specific behaviours, abilities, interests and values are attributed to one sex, then **sex stereotyping** is taking place... Behaviour that results from the underlying belief in sex role stereotypes is referred to as `**sex bias'...** Any action that specifically denies opportunities, privileges or rewards to a person or a group because of their sex it is termed **sex discrimination.**

It is clear that the power of sex role stereotypes is great and the cost is high for everyone: boys and girls and women and men. Sex-role stereotypes prevent boys and girls from having valuable human experiences...They create social and institutional barriers against the development of interests, goals and talents in young people...The human cost in terms of discouragement, sadness, fear and alienation is incalculable. (Cushner, Kenneth H. pp. 199-200).

In all types of work done by men and women, a distinction can be made between productive work (production) and reproductive work (reproduction). **The productive work** includes the production of goods and services for income or subsistence. This work is recognized and valued as work by individuals and societies and get included in national economic statistics. Both men and women perform productive work, but not all of this is valued or rewarded in the same way. **The reproductive work** encompasses the care and maintenance of the household and its members, such as cooking, washing, cleaning, nursing, bearing children and looking after them, building and maintaining shelter. This work is necessary, yet it is rarely considered of the same value as productive work. It is normally unpaid and is not counted in conventional economic statistics. It is mostly done by women. The **role** and the **status** are interrelated. This means a **low status** is accorded to women and women's low status is perpetuated through the low value placed on their activities.

Sex-bias or sex-discrimination can also be seen in terms of **Access to resources** or opportunity to make use of them; **control over resources** or the power to decide how they are used and who has access to them. Women often have access (to resources) but no control over them. (March, Candida. Smyth, Ines and Mukhopadyay, Maitrayee. P.19)

III. Gender as a Development Issue

The social nature of 'gender' is evident in the variation between attributes and activities considered male and female when comparisons are made across cultures, between classes and ethnic groups in the same culture, or in changes over time. Two persistent facts can however be observed across time and place;

- the importance of gender as a basis of the social division of labor. Men and women do different types of tasks and have different jobs within the family, in household production and in the market place.
- Women have less access than men to resources, rewards and power.

The division of labor along the lines of gender is a key concept in attempts to understand and to address inequalities between men and women. It is often seen as both reflecting and reinforcing the subordinate position of women.

The division of labor is often justified by the argument that the roles of men and women are complementary, that two halves are needed to make the whole. It is important however to examine how such a complement is masking the existence and significance of inequality between men and women.

The gender is a valuable concept in that it encourages the identification of social structures, practices and ideologies that perpetuate and reinforce the unequal positions of women and men, and the unequal relations between them. This is a necessary basis for the development of strategies to redress these inequalities.

Everyone has need for food, housing, income, education, good health etc. However, women's **gender needs** arise from the gender division of labor and their subordinate position in relation to men and in the society. There are two types of gender needs.

Practical gender needs: these are the needs women identify to assist them to perform better the tasks they are already doing. Practical gender needs are concerned with inadequacies in living conditions such as water provision, sanitation and health care, employment and enlarging their access to resources or free time. They are practical in nature and are in response to immediate perceived necessity. Meeting practical gender needs improves the quality of women's lives and enables them to be more efficient at what they already do, but it does not challenge the gender divisions of labor and women's subordinate position in society.

Strategic gender needs: These are the needs which women identify because of their subordinate position in terms of their relationship to men and in society. Strategic gender needs vary according to particular context. They may relate to the gender division of labor, or to power and control. They may also include issues such as legal rights, equal wages, domestic violence, women's control over their own bodies and fertility. Meeting strategic gender needs assists women to achieve greater equality, seeks to change existing gender roles and thereby challenges women's subordinate position. (Understanding GAM A Manual)

Policy Approaches to Women

Policy approaches to women is seldom explicitly stated. However, they can be recognized from the role of women being addressed, and the gender needs (benefits) women are expected to gain from the project or program. There are several approaches in practice and they came in to vogue at different points in time, but still, these approaches are observed in the women's development programmes, though each one that came up was an evolution from the previous one.

Welfare Approach: This role focuses on women's role as wives and mothers offering household support to men, who are seen as the work-force and thus the main target for development. Here, the women will benefit from development either through working men, and/or through resources in support of their needs in the domestic arena such as nutrition, education, family planning, health facilities, food aid, availability of fuel and water. This approach focuses on the **reproductive role** and meets the **practical gender needs.** The period during which this approach was most popular was between 1950 –1970, though it is still being widely practiced.

Equity Approach: This approach seeks to promote women's status, power and control so that they are more equal with men. It also recognizes women's active role in development, particularly through their productive role. It seeks to challenge the power of men over women and to end discrimination. It is an interventionist approach, working through changes in legislation of activities concerned with women's rights. This is a top-down intervention from the State.

This approach recognizes women's triple role and meets **strategic gender needs,** which was adopted during 1975-1985 - the UN Decade for Women.

Anti-poverty Approach: This approach focuses on women's problems as the 'poorest of the poor' and offers poverty alleviation as solution, not equality with men. It aims to increase women's income earning capacity through income generating projects, skills training,

introduction of appropriate technologies, literacy etc. In this approach, women's poverty was seen as problem of under development and not of subordination.

This approach focuses on the **productive role** and meets the **practical gender needs.** The period during which this was introduced was 1970 onwards.

Efficiency Approach: This approach views women essentially as a major resource in development, and not as beneficiaries of intervention. It points out that women being half the world's population and already contributing to all economies, but still not sufficiently used. For development to become more efficient it must include the participation of women. Women have the capacity to compensate the declining social services by use of their 'free' time. It puts women into mainstream development and assumes that they will benefit automatically by their participation.

This approach recognizes women's triple role with a focus on the **productive and community managing roles.** It meets the **practical gender needs** and it came into vogue in 1980s, when it was most popular.

Empowerment Approach: This approach differs from the equity approach in origin and strategy. It emerged from women who have been involved in liberation struggles and grass roots level organizations and is articulated by feminists. The purpose of this approach is to empower women through greater self-reliance as they seek to influence their own change, and the right to determine their own choices in life. They also seek to gain control of and access to resources.

This approach recognizes the triple role of women and seeks to meet both the **strategic and practical gender needs.** The period in which this came into focus was 1975 onwards, and accelerated during 1980s (Moser, Caroline O.N. 1989)

IV. Position of Women

Position describes the place of women in society in relation to that of men. Changing women's position requires addressing their strategic gender needs including equal access to decision making and resources, discriminations faced in employment, land ownership etc. It also requires addressing the issues related to the way gender determines power, status and control over resources.

In the Foreword of the United Nation's " Human Development Report " of 1995, which focused on assessing the level of gender equity and discrimination in the nations of the world, James Gustave Speth says " The most persistent (form of disparity in the world) ... has been gender disparity....Women still constitute 70% of the world's poor and two thirds of world's illiterates. They occupy only 14% of managerial and administrative jobs; 10% of parliamentary seats and 6% of cabinet positions. In many legal systems they are still unequal. They often work longer hours than men, but much of their work remains undervalued, unrecognized and unappreciated... And the threat of violence stalks their lives from cradle to grave. (Batliwala, Srilatha.1996). Gender disparity in the Indian society is clearly visible in the census and other data on gender related studies in India.

Gender Disparity as Reflected in Demographic Data

Female-Male Ratio: This indicator of gender inequality is important as it sheds light on other aspects of gender relations and through that on a number of interlinked features of Indian society. "It is well known that the female-male ratio in India has declined through much of the twentieth century. More precisely, India's female-male ratio declined almost monotonically from 0.970 to 0.930 between 1901 and 1971 and has remained close to 0.930 since 1971, reaching its nadir of 0.927 in 1991. Since then there has been some increase; the latest figure from the 2001 census is 0.933. (Drez, Jean and Sen, Amartya p.236)

"India as a whole has an exceptionally low female-male ratio... There are large variations between different states. The female-male ratio is particularly low in large parts of north India, especially the north-western states (e.g. 0.86 in Haryana and 0.87 in Punjab) and comparatively high in the South (0.99 in Tamil Nadu, 0.98 in Andhra Pradesh and 0.96 in Karnataka). In Kerala, the female-male ratio is well above unity, in fact it is as high as 1.06..." Since 1901, the female-male ratio has steadily declined in some states (e.g. Bihar, Orissa, Tamil Nadu) steadily increased in others (mainly Kerala and Himachal Pradesh) and followed intermediate patterns elsewhere". (Drez, Jean. Sen, Amartya p.236)

"These regional patterns of female-male ratios are consistent with what is known as the character of gender relations in different parts of the country. The north western states are notorious for highly unequal gender relations, some symptoms of which include the continued practice of female seclusion, low female labor- force participation rates, a large gender gap in literacy rates, extremely restricted female property rights, strong boy preference in fertility decisions, widespread neglect of female children and drastic separation of a married woman from her natal family. In all these respects, the social standing of women is relatively better in South India and also in much of the eastern region." (Drez,Jean.Sen, Amartya p.231.)

The decline in female-male ratio is surprisingly age specific. "For India as a whole, the female –male ratio of the population in the 0-6 age group has fallen from 94.5 girls per hundred boys in 1991 to 92.7 girls per 100 boys in 2001.This reflects not a rise in female vis-à-vis male child mortality but a fall in female births as compared with male births and is almost certainly connected with the spread of sex selective abortion". (Drez, Jean. Sen, Amartya pp. 257-258).

"There has been no improvement whatsoever in the relative survival chances of girls vis-à-vis boys in the youngest age groups. Early childhood is a period of high mortality. This persistent survival disadvantage of young girls is bound to exert a major downward effect on the overall female-male ratio." (Drez, Jean. Sen, Amartya p.238) "The all India female –male ratio decline seems to reflect a combination of the 'mortality decline effect' with an adverse 'changing mortality bias effect. Or at the very least, a failure to remove '**anti-female bias in survival'.** This applies particularly in the younger age group, where the anti-female bias remains very strong."(Drez, Jean. Sen, Amartya p.238). "Punjab and Haryana continue to have the lowest sex ratios in the country but surprisingly in the smugly

superior South, all states, even Kerala, have registered an adverse sex ratio. Jharkhand followed by three northeastern states have the best female child sex ratios countrywide which suggests that tribal societies recognize the need for a balanced sex ratio and gender equity." (Chandra, Shailaja)

It is noteworthy that taking all age groups together, the overall survival chances of Indian women are now a little higher than those of Indian men, as can be seen from recent **overtaking of male life expectancy by female life expectancy** (the gap between the two is around two years in favour of females according to recent estimates) (Drez, Jean. Sen, Amartya pp239-40). Though this appears to be positive, the anti-female bias in survival, namely, high mortality in early childhood makes it negative. The decline of the female-male ratio in India appears to be sharper among disadvantaged castes. In 1991, the female-male ratio among scheduled castes was 922 per thousand, compared with 927 in the population as a whole. (Drez, Jean. and Sen, Amartya p.241)

Many social issues relating to women and gender relations receive little attention. These include widespread violation of women's property rights (besides the persistence of anti-female biases in the law itself), endemic violence against women, the economic and social rights of sex workers, the institutional and social requirements of better political representation of women... Another striking example concerns the well being of widows. In India widows represent 6.5% of the total female population or more than a million women in absolute terms. There is a good deal of evidence of the deprived condition of widows in India. Only 1.9% of all Indian men are widowed, compared with 6.5% of women... The consequences of losing one's spouse are very different for men and women. A widower has greater freedom to remarry than his female counterpart. He also has property rights, wider opportunities for remunerative employment, and a more authoritative claim on economic support from his children...The recent surveys carried out show there are close links between the position of widows in society and a whole range of patriarchal institutions such as patrilineal inheritance, patrilocal residence, remarriage norms and the gender division of labor. (Drez, Jean and Sen, Amartya. Pp263-266)

It is rather striking that the demographically 'backward' regions of India (where mortality and also fertility are particularly high) tend also to have highly unequal gender relations. This applies particularly to the large north Indian states (Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan). Conversely, states which have experienced rapid progress in improving health and reducing mortality and fertility are often those where women play an important social and economic role. Striking examples include Kerala, Himachal Pradesh and Manipur. The empowerment of women has had a different basis in each case, involving for instance, early promotion of female literacy, the influence of matrilineal communities, the economic roles of women and other sources of female emancipation. The common feature is that women have ended up with a far more equal and active role in the society than their sisters in the large northern Indian states. Correspondingly, there has been far more progress in the fields of health and mortality reduction, not just in terms of reducing the female disadvantage in survival, but also in improving survival chances for everyone...Given the gender division of labor that prevails in most of India, nutrition, child health and related matters typically depend primarily on women's decisions and actions.

It is therefore, perhaps unsurprising that social achievements in this domain are more impressive where women are better educated, more resourceful, more valued, more influential and generally more equal agents in household and society. (Drez, Jean. and Sen, Amartya. Pp271-272)

Gender Disparity as Reflected in Production Process

"India is swept by a wave of revolutions. The "**Green Revolution",** which increased rice and wheat yields since the early sixties through agro-technical modernization, was followed by a " **White Revolution",** which turned traditional milk production upside down, and a "**Blue"** one which modernized fish production. These revolutions of different colors have the same goals and employ the same methods. They were introduced with the claim that they would increase productivity, secure the supply of staple foods, and improve the nutrition and income situation of the poorest segments of the population. They hope to achieve this goal by completely changing traditional production methods, using modern technology, and investing large amounts of capital which is made available to subsistence producers in the form of credits. A radical change of production techniques in farming, milk and fish production of course has an impact on all working in these sectors, men as well as women, on the division of labor and thereby on the relationship between the sexes." (Wichterich, Christa. P1)

This is elaborated in terms of the actual changes on the farm operations by men and women: "Traditionally `female' jobs in different production phases are being turned over to men with the new technology: where women used to dispense cow manure, men now spread chemical fertilizers; where women used to dig ditches for irrigation, men now lay hoses through which a generator pumps water into the fields. Mowers, threshers and peelers are already replacing women in many fields during the harvesting season...They are thus pushed to the lower end of the new employment, qualifications, and income hierarchy which the "Green" revolution created."...Families with small holdings went deep into debt to be competitive in the capitalized agricultural economy. In order to meet stifling interest payments, small farmer's wives hired themselves out as workers on neighboring large farms. With the additional income from dependent work – hereto forth unknown social humiliation – the women are financing the "Green" revolution which their husbands implemented on their own fields...While there is a shortage of labor in Punjab, women looking for work can find employment as day laborers, there is an oversupply of workers in Tamil Nadu. Here the smallest farmers could not finance the new technology for long and hence they lost their lands. In 1951, 47.5% of women working in agriculture still owned their own farms while only 14.7% did so in 1971. Due to oversupply of labor, not all impoverished rural women could find work in the fields.

Conventional animal husbandry and milk production, which had been a traditional domain of women, was revolutionized by crossbreeding by imported high yield cattle and an establishment of a technological infrastructure, including dairies, cold storage and automatic milk dispensers in the cities...However, the key position of women changed in the process. Earlier they had to take care of an undemanding, robust cow which fed on hay and harvest wastes, whose milk they either sold locally or processed for their own consumption as

butterfat or cheese. Today they have to feed, milk and care for several high-yield cows which is more time consuming as these high-bred animals are more sensitive. They then deliver the milk to the collection point of the dairy cooperative and are excluded from processing and marketing of their product. Their work load has increased but their scope of activities has been reduced. Women's activities are now restricted to domestic sphere. The "White Revolution" has pushed women from the center of the milk production process to the invisible edge, from the public domain to the private sphere...

The 'Blue' Revolution has also destroyed the basis of traditional division of labor between men and women. There was job equality in traditional fishing industry: men rowed their catamarans along the coast and brought their catch to the beach where women placed the fishes into baskets, carried them to the nearest market and sold them. They also conserved fishes by drying or salting for own consumption, sometimes also for sale, and they knotted nets. This traditional job division was destroyed when medium-sized motor boats came into use in coastal waters and large trawlers in deep-sea waters. Since the fifties, fishing has become more and more the business of private, sometimes also foreign enterprises, of wholesalers, freezer and refrigeration equipment manufacturers. This new polarization of the sexes by the development process – progressive men on the one side and traditional women on the other – represents a loss of status and power of women in society and in the family. Economically and socially they are becoming marginalized and they are in fact all-round losers in the production process. (Wichterich, Christa. Pp. 18-20)

A study conducted by the Centre for Social Research (Delhi) and supported by United Nations Conference on Trade and Development (UNCTAD) has found that women get an all - round raw deal in the fishing industry that employs over 11 million people across India. The study done in Kerala (Kochi and Kollam) and Gujarat (Porbandhar and Junagarh), found that against the average monthly wage of Rs.560 (+/- 78) for men, a woman worker made a paltry Rs.289 (+/ - 98) (Sinha, Ashish.)

Gender Disparity in Socio-Cultural context

Gender discrimination in Literacy and Elementary Education:

Literacy is considered an essential tool of development. The evidence of potential benefit of literacy to women is impressive. Lalage Bown's review of women's literacy programmes (1990) finds case study evidence of social (a reduction in infant mortality, greater readiness to present children for immunization, better child nutrition, an enhanced readiness to send children including daughters to school); economic (greater willingness to use banks, a readiness to participate in and establish new forms of economic organization, establish income generation groups); and personal benefits (a release from fears of humiliation and powerlessness, readiness to speak in public). (Derbyshire, Helen. Pp 57-58)

As per Census of India 2001, there is a large disparity in the literacy rates of men and women in India. Though the literacy rate in India as a whole has steadily increased from 1951 to 2001, the difference between male and female literacy persists, 21.69% (Male literacy was 75.85% and female literacy was 54.16%) in 2001. The gender gap in Elementary

Education is seen both in enrolment and drop-out percentages. Enrolment of boys was 64% and of girls was 49.8% at the primary level; and enrolment was 25.3% for boys and 17.5% for girls at the upper-primary level. The drop-out rates were 39.7% for boys and 41.9% for girls at the primary level; and 50.3% for boys and 57.7% for girls at the upper-primary level. (Selected Educational Statistics 2000 – 2001 Ministry of HRD)

The effect of gender on schooling decisions and its variability across the states in India is widely recognized. The male advantage in enrolment is slight, less than 5% in Kerala, Himachal Pradesh, Goa and the north eastern states. Then there is a set of states in which the male advantage is substantial and always statistically significant, from Assam at 7.3 percentage points to Maharashtra at 13.5 percentage points. Then there is a jump and there are nine states where the male advantage exceeds 15 percentage points. Among these states, 18.6 percentage points in Orissa to a dismaying 45.8 percentage points in Rajasthan where boys are more likely to be enrolled in schools. These states also include several large states such as Uttar Pradesh with 34.5 percentage points. All India average gender gap is 23.7 percentage points...The effects may be even more severe for the poor. In rural areas of India, on an average, a girl from a poor (bottom 20%) household is 55.2 percentage points less likely to be in school than a boy from a rich (top 20%) household; while in Uttar Pradesh she is 71.7 percentage points less likely. In Bihar and Rajasthan the combination of gender and wealth gaps produces a gap between the most and least socially favoured groups of a staggering 86.3 and 86.4 percentage points. (Filmer, Deon. and Pritchett, Lant pp. 150-151).

Socialization of girls and gender based division of roles determine whether girls will be sent to school, why and for how long? In other words, gender ideology underlies the societal perception regarding the role of girls' education. The difference in educational attainment that is observed between boys and girls provides evidence that educational motivation is highly gender-specific. Keeping this point in view, parents of drop-outs were asked certain gender specific questions relating to their preference for son, participation in household chores and also questions to assess parents' level of motivation in relation to education. It was found that more than three fourths of parents (79%) preferred son over daughter while only 21% did not have any preference. Parents preferred son over daughter for old age security, financial support and social status. Parents also felt that they would gain economic return by investing in case of sons as against daughters who are considered as liability and others' property. In spite of improvement in educational and economic status, there is reinforcement for son preference and daughter disfavor.

Majority of parents viewed that education is important for sons because they get better employment and earn money, but for daughters they perceived education is important for better marriage partner (48%), ability to read and write (18%), for educating their children and for better adjustment (12%)...When parents were asked about the tasks to be performed by children majority (77%) felt that they should perform gender-specific tasks, i.e. washing and cleaning home, cooking etc. should be done by the daughter, while outside work such as buying grocery, paying bills, farm labor should be done by son. Only 23% responded

that both types of work could be performed by both the sexes. Children from poor families assist their parents in various household activities. The cost of schooling rather than return (benefit) from schooling is the basic determinants of parental decision in poor socio-economic context. 64% of girls and 36% of boys assisted in family chores. (Sanwal, Shilpi Suniti pp.399-409)

Gender Disparity in Health Status

"The World Economic Forum, in a report titled the **Global Gender Gap 2009** has quantified the magnitude of gender-based disparity in 134 countries. Appallingly India ranks the very last on health and survival and is at the 114th position overall. Comparing Gender Equality derived from three National Family Health Surveys spanning 13 years, a report published by the International Institute of Population Studies (IIPS Mumbai 2009) also presents a miserable picture. Far from improving, the gender gap is widening." (Chandra, Shailaja.)

"The fact sheets of the third round of the National Family Health Survey (NFHS- III), conducted in 29 states in 2005-06, indicate that the health and nutrition status of India's women and children is in vast and systemic crisis... Among married women in the 15-49 age group, the prevalence of anaemia has risen from 51.8% in 1998-99 to 56.1% in 2005-06. No less than 57.9% of pregnant women suffer from anaemia, which has also risen from children aged 6 to 36 months - 79% were anaemic in 2005-06 compared with 74.2% in 1998-99. There are of course wide variations across states in both levels and trends in indicators of health and malnutrition. While Punjab and Kerala report the lowest proportion of underweight children (27% and 28.8% respectively), in Jharkhand and Madhya Pradesh more than 59% of children below the age of three were underweight. Child malnutrition has actually risen in seven states, most rapidly in Madhya Pradesh and Haryana...As malnourished children are unlikely to reach their full human potential – the next, the anaemic and malnourished young girls are likely to grow into mothers who give birth to low birth weight babies." (Editorial "The Hindu" 02-03-2007)

'State of World's Mothers', brought out by 'Save the Children' says India is seeing alarming inequalities with respect to health services reaching the poorest child and the wealthiest... While 66% of the poorest children in India receive none or minimal health care, the figure stands at 31% for well off children, who are not covered ...Worrying survival gaps for girls was pointed out – for every five boys who die, eight girls die...The main reason for the gender gap in India is the inequity of health care for male and female children. Girls are often brought to health facilities in more advanced state of illness than boys, and taken to less qualified doctors when ill...Less money is spent on girl's health when compared to boys. As a result, girls are less likely to receive the medicines and treatment they need. (Sinha, Kaunteya. 'The Times of India' 08-05-2008)

Female Foeticide

Technology for sex determination first came into being in late 1970s. Although foetal sex determination and sex selection is a criminal offence in India, the practice is rampant... The 1991 census showed that two districts had a child sex ratio (number of girls per

thousand boys) less than 850; by 2001 it was 51 districts. Child rights activist Dr. Sabu George says foeticide is the most extreme form of violence against women. "Today a girl is several times more likely to be eliminated before birth than die of various causes in the first year. Nature intended the womb to be a safe space. Today the doctors have made it the most unsafe space for the female child," he says...Foeticide is also one of the most common causes of maternal mortality. The sex of the foetus can be determined only around 14-16 weeks of pregnancy. This means most sex selective abortions are late. Abortion after 20 weeks is illegal in India. Foeticide is related to a host of other social problems such as dowry. Daughters are considered an economic liability as dowry becomes a heavy burden on the family finance. As well-educated groom demand more dowry, parents are hesitant to send their daughters for higher education. (Thapar, Sumita. The Hindu. 18-03-2007)

Age at Marriage

India introduced laws against child marriage in 1929 and set the legal age for marriage at 12 years. The legal age for marriage was increased to 18 years in 1978. "Nearly half the women in India are married off before they reach the legal age of 18...According to researchers specializing in social and behavioral sciences at Boston University School of Public Health (BUSPH), economic and educational reforms in India have failed to lower the prevalence of child marriages, fuelling risks of multiple unwanted pregnancies, their termination and sterilizations... More than one in five (22.6%) were married before age 16, while 2.6 % were married before age 13. Nearly half (48.4%) of women who were married as children reported giving birth before they turned 18." (Sinha, Kounteya) "Since not even half the couples in the reproductive age group use any contraception, anaemic, adolescent girls and malnourished women continue to deliver underweight children, who either succumb or become prey to infancy and childhood diseases. (Chandra, Shailaja)

Gender and Mental Health

Mental Health: Defined in 1981, WHO Report includes social dimensions of mental health: "Mental Health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality." This definition brings out the crucial role of social context and highlights the importance of justice and equality in determining mental well being.

"**Gender** is conceptualized as a powerful structural determinant of mental health that interacts with other structural determinants including age, family structure, education, occupation, income and social support and with a variety of behavioral determinants of mental health. Understood as a social construct, gender must be included as a determinant of health because of its explanatory power in relation to differences in health outcomes between men and women... A gendered, social determinants model offer the only viable framework for examining evidence on all relevant factors related to women's mental health. From this perspective, public policy including economic policy, socio-cultural and environmental factors, community and social support, stressors and life events, personal

behaviour and skills, and availability and access to health services may all be seen to exercise a role in determining women's mental health status... The importance of gender differences in mental health is most graphically illustrated in the significantly different rates of major depression experienced by women compared with men." (WHO, Women's Mental Health: An Evidence Based Review p.12).

Two measures that attempt to operationalize gender development and capture the disparity between women and men have been developed by the United Nations Development Program (UNDP). One is the Gender related Development Index (GDI) and the other is the Gender Empowerment Measure (GEM). The GDI aims to rank countries on their absolute level of human development and their relative scores on an index of gender equality. The same three indicators that are used in the Human Development Index (HDI), namely life expectancy, educational attainment and income are used for the GDI. The GEM provides a measure of gender inequality in the economic and political participation and decision making. .. Both measures have received criticism...The UNDP measures may be less than perfect, but they remain useful tools for providing an overview of differences in gender development and empowerment between countries. All the available data point to the universally inferior position of women (WHO Report p.16). The impact of various life stressors that set apart women from men are listed here: "It is vital that women's health in general and women's mental health in particular, are examined within a social model which gives an account of the physical and mental health effects of common life stressors and events that are disproportionately experienced by women. Clearly this cannot be confined to child bearing and reproductive events but must also include the impact of poverty, single parenthood, employment status, 'double' shift of paid and unpaid work, lower wages, discrimination, physical, emotional and sexual violence and psychological costs of child care and other forms of caring work".

The Executive summary of the The World Health Report (WHO 1998) categorically states that, "Women's health status is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination. Today the status of millions of women worldwide remains tragically low. As a result, human well being suffers and the prospects of future generations dimmer." (WHO report, p15.)

"Gender blindness to the possible influence of systemic injustice and discrimination as inducements to depression and despair is readily apparent in the large body of research on how women's reproductive functioning affects their mental health. In a review of research on the link between reproductive function and psychiatric syndromes, not a single study mentioned, let alone examined, how the denial of women's reproductive rights might affect their mental well being...It seems astonishing that issues such as forced sterilization, having one's concerns dismissed or trivialized, not being asked for consent to invasive procedures or tests, being denied privacy or dignity when intimate gynecological examinations are performed, having low or no access to accurate health information or to safe, effective and affordable methods of fertility regulation, safe care in pregnancy and child birth and affordable methods of preventing or effectively treating sexually transmitted diseases, have never been seen to play a role in women's emotional well being. Inadequate reproductive

health care and violation of reproductive rights result in physical harm, even death. Despite this their psychological dimensions have been ignored almost as if women's bodies and what is done to them had no effect on their minds and could be denied" (WHO report p.25).

To elaborate specifically, "Little education, early age at marriage, adolescent pregnancy, repeated pregnancies at short intervals due to lack of access to or the cultural unacceptability of family planning, son preference and less food being given to girls and women, all increase the likelihood of reproductive health problems. All are influenced, if not caused by social and cultural, not biological forces."...The emphasis on reproductive biology is likely to stem from the view that women's health is synonymous with and reducible to those illnesses or conditions related to women's reproductive health. This view is indicative of a dualistic style of thinking characterized by the use of binary terms where one term is always privileged in relation to the other. The privileged term is regarded as the norm and its opposite is defined only in relation to it and is devalued accordingly, for example, rational/irrational, objective/subjective, thinking/feeling, culture/nature, mind/body, masculine/feminine."...The splitting of body from mind and identification of women and their health with the body in general and reproductive functioning in particular has led to neglect of women's mental health. Furthermore, its social structural determinants using biological difference from men as the chief organizing principle, women's health, in the past, was seen to fit within the ambit of Obstetrics and Gynaecology. Within this bio-medical framework, women's health was confined to such issues as breast and cervical cancer, pre-menstrual syndrome, contraception, pregnancy and child-bearing, psycho endocrine problems, post-natal disorders and disorders of menopause'. (WHO Report, p 26)

Violence against Women

"The term 'violence against women' means any act of gender based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. Accordingly, violence against women encompasses but is not limited to the following:

(a) physical, sexual and psychological violence occurring in the family including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation

(b) physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptive, female infanticide and prenatal sex selection" (WHO

Report,p.67-68). Violence against women by their intimate partners or men not known to them is the most prevalent and gender based cause of depression in women. This type of violence has the three features identified in social theories of depression, namely, humiliation, inferior social ranking and subordination, and blocked escape or entrapment...Violence can and does occur over the life-span, from childhood to old age, with elder abuse being the recent aspect of domestic violence....Violence at work is also emerging as a significant problem. (WHO Report p.65)

The association between violence and depression and anxiety in women has now been well documented...Humiliation and estrangement are defining features of partner violence...Violence involves loss and defeat at several levels – the loss of a sense of self and other (as previously imagined), the loss of safe relationship and the loss of a cherished idea (being loved and unharmed)...Violence, by forcing submission and enforcing inferior social ranking and subordination, engenders a sense of defeat and a loss of self-esteem....Perhaps the most extreme form of psychological distress following violence is suicidal behaviour. The pivotal role of violence in such behaviour is becoming increasingly clear. (WHO Report p.76, 77)

Multiple somatic complaints, physical and psychological disorders and altered health behaviours have all been documented as consequences of violence. These include chronic, pelvic and other pain syndromes, negative pregnancy outcomes, gastro-intestinal problems such as irritable bowel syndrome and inflammatory bowel disease, headaches, chronic fatigue and sleep pattern disturbances, pain syndromes, eating disorders, substance use disorders, post traumatic stress disorder, certain personality disorders, stress related illnesses, suicidal tendency and self harm, lowered self-esteem, depression, anxiety and other forms of psychological distress, difficulties in sexual and interpersonal relationships, unsafe sex behaviors and both delayed seeking of preventive and prenatal health care and increased rates of emergency and primary health care utilization (WHO Report pp.81-82).

The interlocking causes of violence against women are embedded in every level of society – the individual, family, community and the socio-cultural setting. For this reason, isolated approaches to the reduction of violence cannot be effective. (WHO Report)

Gender and Mental Health in Indian Context

Gender specific risk factors for common mental disorders that disproportionately affect women include gender based violence, socio-economic disadvantages, low income and income inequality, low or subordinate social status and unremitting responsibility for the care of others.

Although there do not appear to be sex differences in the overall prevalence of mental and behavioral disorders, there are significant differences in the patterns and symptoms of the disorders. These differences vary across age groups.

Common psychological problems observed in women	Common psychological problems observed in men
a. Frequent health problems b. Body aches c. Decreased appetite d. Decreased/lack of sexual interest and pleasure e. Sleep disturbances f. Lack of concentration and poor memory g. Decreased or lack of interest, boredom and feeling lonely h. Feeling of helpless and worthless i Worrying, getting upset easily, irritability, anger and jealousy j. Fearfulness, feeling of insecurity, k. Feeling of inferiority, lack of self- confidence, excessive shyness l. Sadness with crying spells m. Guilt feeling n. Indecisiveness, conflicts and confusion	a. Aggressive, abusive and assaultive behavior b. Wandering behavior and restlessness c. Violent in behavior d. Frustration e. Decreased concentration f. Apathy and less motivation

Presently women in our culture are at high risk to develop psychological problems and mental disorders because of the following factors

Male Preference: People prefer to have a male child. Female foeticide is on the rise. Female child gets rejected and survives as an unwanted child. Gets low priority in the family.

Weaker sex: People believe that women are physically and mentally weak. The age old and popular belief is that a female has to be under the protection of her father, husband and then son as she cannot be on her own. This socialization makes the female child to believe that she cannot compete with male counterparts and takes up the passive role of a follower.

Socialization Process: Girls are socialized to be shy, meek, to obey instructions without questions, afraid to go out alone, suffer in silence, make sacrifices, neglect personal needs etc. They are made to take up household chores and child care as major responsibilities in their life. Facing stressful situation leads to mental breakup.

Sexual exploitation: Women are being used as objects of sexual satisfaction. Sexual harassment is seen everywhere. Women are expected to fulfill and adjust to the sexual desires of their husbands, not being treated with dignity and viewed as objects for sexual satisfaction.

Pregnancy and child birth: Women take the full responsibility and blame for child birth. Generally women undergo tubectomy to limit the family size. They are blamed for not having male child or when the child is born with disability. With a disabled child, it becomes the women's responsibility to meet the needs of the child.

Conflict between mother-in-law and daughter-in-law: It is common to see these conflicts in most families. Both feel insecure and compete for attention from others. Each one tries to exploit and ill treat the other. They compete for power, status and to have control over the resources.

Issue of dowry: Now in almost all sections of society large sums of money and materials are demanded from the bride's family as dowry. The demand continues even after marriage and becomes cause for fights leading to marital disharmony and negativity, becoming a root cause for mental illness. It is very evident from the increased dowry deaths.

Economic dependency of women: Women in general are not economically independent. They may earn and may have property in their name, but they cannot spend money as per their wishes. Husband, in-laws, and sons have to permit her to spend or use the assets.

Triple burden of women: Working women face the problems of triple burden as they have to work outside the home and are also expected to take full responsibility of maintaining the home and child care responsibilities. Women often need and are expected to make compromises in their career for the sake of the family.

Widowhood: After the husband's death, the woman is said to be a symbol of bad omen. She is forced to sacrifice all the pleasures and is treated like an outcaste in order to meet the societal expectations. She suffers from isolation and rejection by others.

Sex differences in the prevalence of mental disorders across the life-cycle

Life-cycle stage	Mental disorder	Male:female difference
Childhood	Pervasive developmental disorder	Males >> Females
	Attention deficient hyperactivity disorder (ADHD)	Males >> Females
	Conduct disorders	Males >> Females
	Learning disability	Males >> Females
Adolescence	Depression	Females >> Males
	Deliberate self-harm	Females >> Males
	Eating disorders	Females >> Males
	Substance abuse	Males >> Females
Adulthood	Depression and anxiety	Females >> Males
	Schizophrenia	Males = Females
	Bipolar disorder	Males = Females
	Substance abuse	Males >> Females
Old age	Dementia	Females >> Males
	Depression	Females >> Males
	Psychoses	Females >> Males

Women are disproportionately affected by mental illness in comparison to men. The difference in the psychiatric morbidity of women in comparison to men is due to biological and psychosocial issues. Biologically, menstruation, childbirth, menopause and underlying biological substrate make women vulnerable to certain types of psychiatric illnesses. Psychologically, women feel more emotional distress than men especially due to hassles of daily life. They react to life events and stressors with more intensity than men. However they maintain better emotional ties with people and seek help more easily and do not use alcohol and other substances as a way of coping difficulties. Apart from the biological causes, the disadvantage of women's roles in society with low social status associated with workload in home management leads to social discrimination leading to low aspirations and low self esteem, ultimately making them more vulnerable to psychological distress and morbidity.

Women seem to show high incidence of mental illness such as major depression, agrophobia, simple phobia, somatisation, histrionic personality disorder, obsessive compulsive disorder. Men whereas, predominate in anti-social personality disorder, alcohol dependence and substance abuse. Life time risk for developing depression is more (2:1) in women when compared to men. Women attempt suicide more, but more lethal and successful attempts. Recent analysis of the epidemiological surveys in India has revealed that prevalence rate of psychiatric disorder among women is 50/1000 and for men it is 40/1000. All the diagnostic categories appear to be more common in women than men except alcoholism, substance abuse, personality disorders and mental retardation.

Most studies report a higher prevalence of conduct disorders in childhood, for example with aggressive and antisocial behavior more among boys than in girls. During adolescence, girls have a much higher prevalence of depression and eating disorders, and engage more in suicidal ideation and suicide attempts than boys. Boys experience more problems with anger, engage in high risk behaviors and attempt to commit suicide more frequently than girls. In general, adolescent girls are more prone to symptoms that are directed inwardly, while adolescent boys are more prone to act them out.

In adulthood, the prevalence of depression and anxiety is much higher in women, while substance use disorders and antisocial behaviors are higher in men. In the case of severe mental disorders such as schizophrenia and bipolar depression, there are no consistent sex differences in prevalence, but men typically have an earlier onset of schizophrenia, while women are more likely to exhibit serious forms of bipolar depression. In older age groups, although the incidence rate for Alzheimer's disease (a degenerative disease of the brain which usually occurs after 65 years of age) is reported to be the same for women and men; however, women's longer life expectancy means that there are more women than men living with the condition.

The high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post Traumatic Stress Disorder (PTSD) following such violence, renders women the largest single group of people affected by this disorder. Depression, anxiety, somatic symptoms and high rate of co-morbidity are significantly related to

interconnected and co-occurrent risk factors such as gender based roles, stressors and negative life experiences and events. Gender differences exist in patterns of help seeking for psychological disorder. Women are more likely to seek help from and disclose mental health problems to their primary health care physician, while men are more likely to seek specialist mental health care and are the principal users of inpatient care.

The course and outcome of mental illness seems to be influenced by gender. Men are socialized not to express their emotions. Culturally they are expected to be dependent on women for many aspects of domestic life, which may contribute to high levels of distress among men when faced with situations such as bereavement and separation. It has been observed in various researches that women have a later onset of illness (schizophrenia), need shorter and fewer hospitalization and better prognosis with medical and family interventions. Women seek more help for physical symptoms and depression than men. Community surveys in India have shown that married women who develop mental illness are abandoned by spouse more often than men with mental illness. However, social support is present to these separated women from their parents and siblings. Women generally control the illness through medication and do not use alcohol or other substances.

Lack of adequate care facilities in the community along with the stigma attached to mental illness and the unanswered question on 'what next?' after their demise forces family members to shift the responsibility of caring for their male mentally ill family member by getting them married. Married men are likely to be cared for and supported by their wives, while married women were more likely to be deserted or divorced by their husbands (Davar 1999), and have experienced physical abuse by their husbands prior to the separation.

Gender bias occurs in the treatment of psychological disorders. Doctors are likely to diagnose depression more in women compared with men, even when they have similar scores on standardized measures of depression or present with identical symptoms. Gender stereotypes regarding proneness to emotional problems in women and alcohol problems in men appear to reinforce social stigma and constrain help seeking along stereotypical lines. They are barriers to accurate identification and treatment of psychological disorder. Despite these differences, most women and men experiencing emotional distress and /or psychological disorder are neither identified nor treated by their doctor. Violence related mental health problems are also poorly identified. Women are reluctant to disclose a history of violent victimization unless physicians ask about it directly. The complexity of violence related health outcome increases when victimization is undetected, resulting in high and costly rate of utilization of the health and mental health care system. Economic and social policies that cause sudden, disruptive and severe changes to income, employment and social capital that cannot be controlled or avoided, significantly increase gender inequality and the rate of common mental disorders.

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CHAPTER 2: METHODOLOGY

Reason for the study

The available information on persons with mental illness and also the staffing pattern of the partner organizations in Bihar and Jharkhand indicated a gender disparity, in favour of men. It was considered useful to study and ascertain the reasons for the existing situation so that action could be taken to overcome the unacceptable gender bias that existed.

Aim of the Study

The study aims at understanding the probable reasons for gender disparities prevailing in the families and communities in the programme area of BNI- NBJK in Bihar and Jharkhand states, and also aims at suggesting strategies to overcome the gender disparity in the programme.

Broad Objectives of the Study

- To determine the status of men and women in the families participating in the community mental health (CMHD) programme areas of NBJK – BNI in Bihar and Jharkhand states in India.
- To determine the status of men and women in Lohardaga (predominantly tribal) and Gaya (predominantly non-tribal) districts in the CMHD program areas of NBJK and BNI;
- To ascertain variations, if any, in the status of men and women with mental illness.

Specific Objectives

- To describe the family profiles of the families in the sample in Lohardaga and Gaya; the profile of people with mental illness in the two districts studied;
- To ascertain the extent of sex stereotyping in terms of the tasks performed within and outside the household by men and women in the families; men and women with mental illness and to assess variations, if any, between the two districts;
- To assess the extent of decision making by men and women within the families in general, by men and women with mental illness and to assess the variation, if any, between the two districts;
- To ascertain the social status of men and women in general; of men and women with mental illness in the two districts;
- To ascertain the extent of 'access to and control over resources' by men and women in families in general, by men and women with mental illness and also variations, if any, between the two districts'

Research Design

Since the study aims to understand the gender disparities, researchers used 'descriptive research design' for the present study. The study describes the gender perceptions of families and communities in the Community Mental Health and Development program areas in Bihar and Jharkhand.

Preparatory workshop on 'Gender and Development

A three-day preparatory workshop on 'Gender and Development' was organized in October 2006 by Basic Needs India at Ranchi for all the NGO partners of NBJK. It was meant to sensitize the partners on the `issues of gender in development'. The workshop was based on the process of self-reflection on analysis of participants' own gender perceptions in daily life and also an analysis of relevant census data on sex-ratio, literacy rates, labor force participation rates with reference to their own areas of work in Bihar and Jharkhand. It was found that in the total population the sex-ratio varied from 900 to 965 women for 1000 men. Overall male literacy rate was 45 to 50% and women's literacy rate was only 22 to 25%. In livelihood activities, the main and marginal workers with income were mostly men and majority of women were non-workers. Reflection on census data analysis helped the participants to focus their attention on the issue of 'gender' and the need to become 'gender aware' in their own work in the area of mental health.

Study Process

Several meetings were held between the Mental Health Programme Coordinator of BNI responsible for the work in the region and the Research Team in BNI to decide on the procedures to be followed from time to time.

- BNI discussed with the Executive Director of NBJK about the study and ways of conducting the study with active support from BNI. An understanding was made that NBJK would coordinate the study in the field and BNI would conduct, support, guide and advise.

Population of the Study

Population of the study was all the men and women in the programme area of the partner organizations in Bihar and Jharkhand. NBJK, the main partner, worked with 25 local level organizations in 15 districts - 8 districts in Bihar and 7 districts in Jharkhand. All the 15 districts are declared as backward, lacking in mental health facilities and infrastructure to meet the needs of people with mental illness locally. The two state- run mental hospitals meet the treatment needs of people with mental illness from the project area.

- **Inclusion criteria**

  1. Head of the family (men) was interviewed using the interview schedule
  2. Families with one member having mental illness and giving consent for the study were included in the study
  3. Families from Tribal and non-Tribal communities having men and women with mental illness were selected for the study.
  4. Men and women belonging to different caste groups were selected for the study.

- **Sampling and Sample Size**

  For the present study, the researchers used purposive sampling in selecting two districts, one in Bihar and another in Jharkhand. As NBJK worked with 25 partners in 15 districts, selection of the two districts were based on representation of Tribal and Non-Tribal communities. Preparation of a demographic profile of the project areas in both Bihar and Jharkhand helped in selecting the two districts, dominated by tribal and backward classes.

Lohardaga district is dominated by tribal population (28% of the district population is tribal) and Gaya district is dominated by backward population (63% of the district population is OBC). The other selection criteria were:

- The districts where the identification of women with mental illness as compared to men with mental illness was low. (The ratio of men and women varies from 90:10 to 52:48)
- The proportion of Tribal and Non-Tribal population was high. Jharkhand has 24% tribal population and mostly the eastern and southern districts are tribal dominated; where as Bihar is almost uniformly distributed with Non-Tribal population and have less tribal population.
- Managing (administrative) capability of the organization was efficient. [The organization must have its presence all over the block; has the capability to manage a large team, monitor the progress daily and if possible feed the data into the computer]
- Considering the Tribal and Non-Tribal population in the working area of CMHD programme, LGSS, Lohardaga and LSSK, Gaya were selected
- Consultation and discussions about the research study were held with the heads, the mental health coordinators and the field staff of these partner organizations, and those willing to participate in the study were selected.

The researchers were not able to take the entire district for the study; hence they limited the study to the project areas of the partners in operation. The areas chosen were 18 villages in Bhandra Block in Lohardaga district of Jharkhand, and 15 villages Paraiya Block in Gaya district of Bihar.

The partners were working with 220 persons with mental illness (PWMI) in the two chosen blocks. The researchers assumed that 220 is the representation of the community and decided to use them as a sampling strategy for selecting the respondents for the study. The field staff had already built rapport with these families; hence it was easier for collection of data from them. Assuming that PWMI in these communities represent the community, respondents were selected purposively. The heads of all the 220 families were selected for the study. These 220 families were taken as sample of the study and heads of these families were interviewed.

The 220 families included 100 families in the 18 villages of Bhandra block and 120 families in the 15 villages of Paraiya block. Out of this, about one quarter belonged to Tribal community and the rest were from Non-Tribal communities, distributed among different caste groups. Families of all PwMI identified under CMHD Programme in Paraiya and Bhandra blocks formed the sample of the study.

Methods of data collection

The methods of data collection were (1) Interviews and (2) Focus Group Discussions. The required data were to be collected through interviews of the heads of the families; through Focus Group Discussion of groups of community members and (3) a check-list on the roles of men and women in the village communities administered individually to those who attended the Focus Group discussions.

Development of the Tool

It was decided to develop an Interview Schedule for collecting the required information in order to meet the objectives of the present study. The process involved in developing the interview schedule includes

- Held discussions with partner organizations to understand the reasons for less number of women approaching them for mental health care.
- Reviewed the census details of both Bihar and Jharkhand to understand the socio demographic profile of the states
- Reviewed the existing literature to understand the gender issues in India
- Reviewed the review and evaluation reports of the project and based on the recommendations made in them, a gender training was conducted for the field staff of all the 25 organizations
- A group of researchers drafted the questions independently, shared and discussed with each other and as a team to clarify the concepts and questions and finalized the draft Interview Schedule.
- The draft schedule was circulated to the senior development practitioners having field experience of more than three decades for their comments. The researchers discussed with the team members once again and finalized the interview schedule.
- The tools of data collection included the following:
  a. Interview schedule for the head of the family
  b. Guidelines for focus group discussion
  c. Checklist regarding the roles of men and women in community
- The interview schedule was field tested in the urban and rural context, administering the same in two families each in urban and rural settings. This helped in further fine tuning the interview schedule.
- Discussed the responses of field test with the research team and made further modifications
- The interview schedule was then translated from English to Hindi, and the same was given for experts to comment on the translation.
- The draft Interview schedule was used for training the field staff in collecting the data.

Description of the Tool

The Interview schedule for the head of the family elicited information on

1. **Socio demographic details of family:** head of family, name, age, sex, educational qualification, occupation, family type, marital history and family income.
2. **Mental Health status of the mentally ill family member:** information about the illness, duration of illness, support source, source and period of treatment and the stage of recovery.
3. **Tasks within and outside home:** tasks performed by men and women within and outside home, role of the mentally ill person in it
4. **Decision making process:** role of women in the family in decision making process, family planning
5. **Social-economic political status:** accessing health care services, spending pattern among men and women, dowry pattern, effect of mental illness in marriage, choice/celebration of gender, economic initiative by women.
6. **Education:** number of years of formal education for men and women
7. **Access and control over resources:** opportunity to access education, owning and maintaining the resources.

CHAPTER 3: RESULTS

The present chapter on 'Results' is organized in two sections:

1. Gender perception of families and communities in general in NBJK-CMHD, program area
2. Gender perception of families and communities with reference to Persons with mental illness.

Section 1 A

Gender Perception of families with Persons with mental illness in NBJK-CMHD Programme area

4.1.1. Profile of the participants in the study

Table 1: Socio demographic profile of the heads of the families participating in the study

Sl. No.	Variables		Number of Responses	Percentage
1.	**District they hailed from**			
	Lohardaga (Jharkhand)		100	100
	Gaya (Bihar)		120	54.5
2	**Sex of Respondents**			
	Male		195	88.64
	Female		25	11.36
3	**Age of Respondents**			
	20-30 years		24	10.91
	31-40 "		48	21.82
	41-50 "		62	28.18
	51-60 "		58	26.36
	61 years and Above		28	12.73
4	**Educational level of Respondents**			
	Non - literates		71	32.27
	Primary		80	36.36
	Secondary		34	15.46
	Higher Secondary		15	6.82
	Graduation		12	5.45
	Others		1	0.46
	Did not disclose		7	3.18
5	**Types of Family**			
	Nuclear		134	60.91
	Joint		84	38.18
	Extended		2	0.91

6	**Caste groups of the families**		
	General Caste	28	12.73
	SC	45	20.45
	ST	55	25.00
	OBC	92	41.82
7.	**Religion followed by the families**		
	Hindu	154	70.00
	Muslim	18	8.18
	Christian	3	1.36
	Sarna	45	20.45

In both the districts studied, the number of respondents varied slightly: 54.5% were from Gaya district; where as 45.45% were from Lohardaga district.

Among 220 families, 195 (88.64%) were headed by a male member and only 25 (11.36%) were headed by a female member. Of the total number of 25, 20 were from Gaya district and only five were from Lohardaga district, the latter being a tribal belt. In the 11.36% of female headed families, women had either lost their husbands or were deserted by their husbands. The families were essentially patriarchal. It is only in the absence of their husbands due to death or desertion women became the head (until the sons grew up). In the sample, 11.36 % is a substantial number.

Age-wise breakup of the heads of the families indicated that over three fourths (76.36%) were between the ages of 30 to 60 years i.e. predominantly middle aged.

Educational qualifications of respondents revealed that most of them were either non-literate (32.37%) or educated up to primary level (36.36%). About a sixth of the respondents (15.46%) had completed secondary education. Only 6.82% and 5.45% of respondents were educated up to higher secondary and graduate levels respectively. Almost all the respondents were from tribal and backward castes. This may be the reason for the low educational levels of the majority of the respondents.

Generally joint family system is more prevalent among the economically well off families which is well visible in the study as among 220 families 60.9% lived in a nuclear family. The frequency of respondents according to their 'caste groups' showed that 41.82% of them were from 'Other Backward Castes' (OBCs), and 45.45% were Schedule Caste (SC) & Schedule Tribe (ST) groups.

Frequencies of respondents according to their 'religion' revealed that 70% of the families were Hindus and 1.36% belonged to tribal group, converted to Christianity. Besides these, a sizeable group followed Sarna religion. (Sarna religion is created by the tribal group who worship Mother Nature but it is not recognized by the Government as a type of religion).

Table 2: Occupation of the heads of families, their source of income, and number of income earning members in the family

Sl No	Variables	No of Responses	Percentage
1.	**Main Occupation of Respondents**		
	Daily Laborer	28	12.73
	Agriculture	162	73.64
	Petty business	19	8.64
	Job	4	1.82
	Lawyer	1	0.45
	Religious priest	2	0.91
	Pensioner	4	1.82
2	**Number of females participating in income earning in the family**		
	No female	59	26.82
	One female	77	35.00
	Two females	56	25.45
	Three females	19	8.64
	Four females and more	9	3. 98
3.	**Number of males participating in income earning in the family**		
	No males	3	1.36
	One male member	60	27.27
	Two male members	94	42.73
	Three male members	42	19.09
	Four male members	13	5.91
	Five male members and/or more	8	3 63
4.	**Monthly Income of the family**		
	Rs.1000 or less than 1000	98	44.55
	Rs.1001 to 2000	77	35.00
	Rs.2001 to 3000	15	6.82
	Rs.3001 to 4000	10	4.55
	Rs.4001 and above	20	9.08

The frequency distribution of the heads of the families with reference to their 'occupation' revealed that the livelihood of 86.34% (180) families depended on agriculture and coolie work. Only 1.82% of them were employed either in the Government or private firms, getting regular monthly income; and 8.64% had their own petty business.

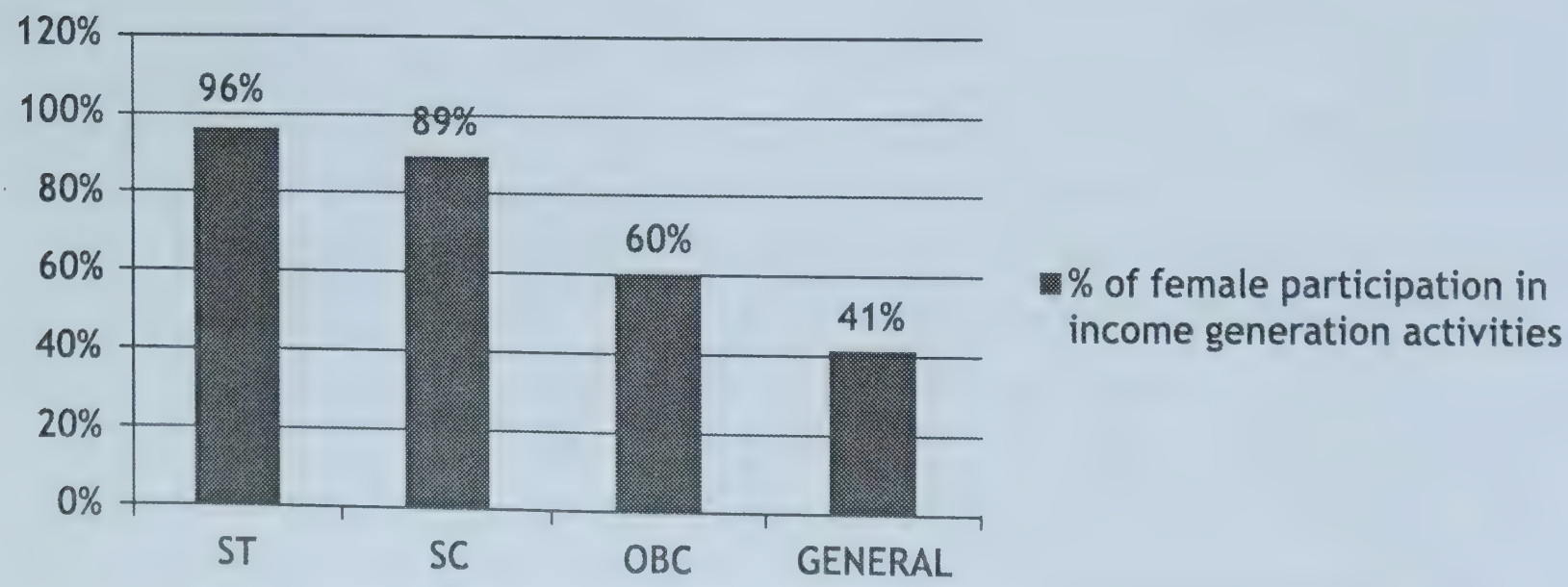
Income of the majority (79.55%) was below Rs.2000 per month. There were only 2 respondents who said their monthly income was between Rs 9001 – 10,000.

Only 26.82% of families reported that female members of their family were not participating in income earning activities whereas 73.18% of the families reported that female members were actively involved in income earning activities. The number of females earning income ranged from one to seven.

Only a small percentage (1.36%) of the male members of the families in the sample was not participating in livelihood activities, whereas 98.64% of the male members in the families were involved in income earning activities. This reflects the patriarchal nature of the society. The male participation in livelihood activities ranged from one to nine members contributing to the family income.

It is interesting to note that in majority of the families the number of females or males engaged in income earning activities was from one to three members. Though the general belief is that male members are the bread winners and females are homemakers, the study showed that in majority of the families both male and female members were engaged in livelihood activities and contributing to the income of the family. This may be because majority of the families were from the low socio-economic group.

'Participation in income generation activity' was cross tabulated with 'religion'. It revealed that there was no difference among Hindus and Muslims in allowing their females members to participate in income generation activity (67% of both Hindus and Muslims), whereas in Sarna religion 95.55% said that their female members were engaged in income generation activities.

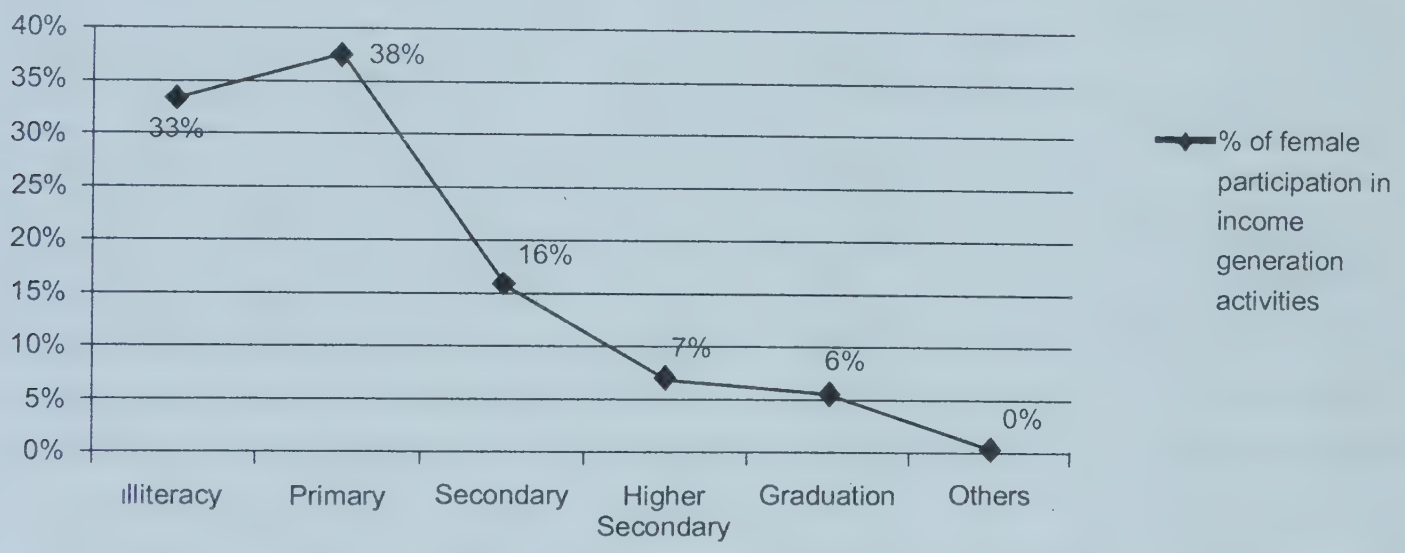


[Graph 1 – % of female participation in income earning activities Vs caste of family]

The cross tabulation of 'participation in income earning activities' with reference to 'castes' revealed that 59.25% of families of general caste (Upper caste and does not include SC, ST and OBC) did not encourage and allow their female members to participate in income earning activities. Among tribal groups, most of the female members (96.37%) were involved in income earning activities and 88.9% of female members of the scheduled caste families also participated in income earning activities.

Money is the source of power. Whoever contributes more to the family income can be expected to have more power in decision making. Though there were females heading families taking responsibilities as their male counterparts were either dead or deserted them, they still seem to expect their male children to take responsibility for the income. This reflects the socialization process of women that men should be encouraged to take up the responsibility of bringing the major share of income to the family. It is rather surprising in the context of the study as women were as much engaged as men in income earning activities.

The female participation in income earning activity when cross tabulated with 'Educational qualification of the heads of the families' revealed that as level of education of the participants increased, female participation in livelihood activities decreased.



[Graph 2 – % of female participation in income generation activities Vs education level of head of family]

The cross tabulation of 'participation of women in income generation activity' with 'the occupation' revealed that job holders, lawyers, pensioners and businessmen did not encourage their female members to participate in income generation activities, where as in families depending on agriculture (78.53%) and coolie work (82.14%) for their livelihood, female members were equally involved in income generation activities.

'Female participation in Income generation activities' was cross tabulated with 'the family income'. The results revealed that in families having monthly income of Rs.5000 and below, female participation in income generation activities was high.

Female participation in Lohardaga district revealed that 91% of them were involved in income generation activities. This may be because majority of them were tribals. In Gaya district 58.31% of the female participated in income earning activities as this area is non-tribal and dominated by Other Backward Castes (OBC). Similar pattern was also observed in the census data of the districts.

4.1.2. Extent of sex-stereotyping in tasks performed within and outside the household

To understand the continued existence or non existence of the tradition of sex-stereotyping in families and the communities with regard to household activities, the researchers included questions in the interview schedule to elicit responses on household tasks performed by men and women, or both

Table 3: Tasks performed by men and women within the household

Sl No	Tasks performed within the house	Male		Female		Both		None		Not Applicable	
		No.	%	No.	%	No.	%	No	%	No	%
1	Takes care of elders	16	7.27	62	28.18	65	29.55	18	8.18	59	26.82
2	Wakes up first in the morning	55	25.00	162	73.64	3	1.36	0	0.0	0	0.0
3	Goes to bed last	43	19.55	175	79.55	2	0.91	0	0.0	0	0.0
4	Takes care of children	5	2.27	145	65.91	65	29.55	0	0.0	5	2.27
5	Prepares children for school	3	1.36	176	80.00	19	8.64	6	2.73	16	7.27
6	Looks after study of children	125	56.82	58	26.36	16	7.27	7	3.18	14	6.36
7	Fetches water	1	0.45	191	86.82	27	12.27	1	0.45	2	0.91
8	Cooks food	2	0.91	216	98.18	2	0.91	0	0.0	0	0.0
9	Gathers fuel	80	36.36	69	31.36	71	32.27	0	0.0	0	0.0
10	Cleans house	4	1.82	213	96.82	3	1.36	0	0.0	0	0.0
11	Cleans utensils	2	0.91	215	97.73	3	1.36	0	0.0	0	0.0
12	Repairs house	166	75.45	17	7.73	37	16.82	0	0.0	0	0.0
13	Washes clothes	5	2.27	197	89.55	18	8.18	0	0.0	0	0.0
14	Takes care of cattle	34	15.45	24	10.91	120	54.55	6	2.73	36	16.36

The household tasks such as waking up first in the morning, going to bed last, taking care of children, preparing children for school, fetching water, cooking food, cleaning the house, cleaning utensils and washing clothes were reported to be the tasks performed mostly by women. Men, whereas, took the responsibility of supporting their children in studies and repairing the house.

The tasks such as taking care of cattle, gathering fuel and taking care of elderly persons were done both by men and women. About one fourth of families reported that they did not have elderly to take care of. About 16% reported that they did not have cattle. Looking at the total picture, it appears that more women were engaged in taking care of the elderly.

On the whole, the household tasks were mostly performed by women, showing a clear emergence of sex-stereo-typing. The household tasks were women's responsibility. The cross tabulation helped in gaining insights in to the patterns of sex-stereo-typing in the communities studied.

Cross tabulation of "Who takes care of elderly people in the house?" with 'the castes' revealed that in 42.8% of families of 'general caste' both men and women took responsibility whereas in SC families, only 30.7% of both men and women took care of the elders. The percentage of taking joint responsibility was still lower in Other Backward Castes (OBC) and Scheduled Tribes (ST).

Cross tabulation of the variable 'taking care of elderly' with 'monthly income of the families' revealed that elderly were taken care of jointly by men and women of the higher income group as compared to lower income group. With the increase in income, the involvement of men in the tasks such as 'care of the elderly', 'guiding children in study', 'repairing house', 'gathering fuel' and 'going to bed last' were observed to be higher.

Cross tabulation of 'taking care of the elderly' with the 'type of family' revealed that a larger percentage of both men and women in joint families (46.4%) cared for the elderly, as compared to the nuclear families where it was only19.4%. The nuclear families may not have elderly living with the family.

In nuclear families, it was observed that males were involved more in house hold tasks such as 'preparing children to school', 'fetching water', 'collecting firewood', 'cleaning house', 'cleaning utensil', 'washing clothes' etc.. A shift in the traditional stereo-type role was observed from the above data. In nuclear families, It was also seen that females were taking responsibilities like repairing the house, guiding children in studies, taking care of cattle etc. thus supporting their male counterparts. Their involvement in so called masculine work was observed from the finer analyses of the data. It was also observed that in nuclear families females were taking more responsibilities in household tasks within and also outside the family. This means increase in the pressure of work and stress level of women. It appears that there was a trend in sharing responsibilities within the household by both men and women. But it needs to be looked at in terms of the load of work carried by men and by women independently so that no one is overburdened.

Almost all the heads of the families said that 'cooking is the responsibility of women as it is their territory and males do not like to explore cooking.'

Table 4: Tasks performed by men and women outside the household

Sl No	Tasks performed by men / women outside house	Male		Female		Both		None		Not Applicable	
		No	%	No	%	No	%	No	%	No	%
1	Takes care of agricultural work	132	60.00	7	3.18	45	20.45	5	2.27	31	14.09
2	Goes to village market for shopping	99	45.00	44	20.00	77	35.00	0	0.0	0	0.0
3	Sells agricultural produce	167	75.91	4	1.82	11	5.00	5	2.27	33	5.00
4	Ploughs land	173	78.64	3	1.36	7	3.18	6	2.73	31	14.09
5	Seeds the field	147	66.82	2	0.91	34	15.45	6	2.73	31	14.09
6	Watering the field	144	65.45	3	1.36	36	16.36	6	2.73	31	14.09
7	Weeding	177	80.45	4	1.82	2	0.91	6	2.73	31	14.09
8	Cutting / harvesting	28	12.73	66	30.00	89	40.45	6	2.73	31	14.09
9	Goes to city market for shopping	182	82.73	10	4.55	28	12.73	0	0.0	0	0.0

The above table reveals that tasks outside the house such as 'taking care of agricultural work', 'going to city market for shopping', 'selling agricultural products', 'ploughing land', 'seeding', 'watering' and 'cultivating land', 'weeding' were primary responsibilities of men. Whereas cutting or harvesting the yield and shopping in village market were tasks of both men and women. A close observation of data revealed that men performed mostly such tasks where money was involved, and assigned those tasks to women where there was no dealing with money. Women seemed to agree to this without questioning as this has been practiced for ages. Even within the household tasks men seemed to have chosen those which fitted with their masculine personality or tasks that could be done without much hard labour.

A close scrutiny of the table revealed that men took responsibilities like 'ploughing land', 'managing the agricultural products', 'cutting or harvesting the yield' etc.. Their involvement in the task was more related to their perception of masculine work expected from men as it also generated money and gave them authority and power within the family. When there was a need for work force to support the agricultural work, men seemed to assign these tasks to female family members as they were not paid for their services as it was free of cost and within their control. Women generally were given tasks such as cutting or harvesting the yield, transplanting etc., which require speed as the time available for these tasks was limited and also it was hard work. Men sold the agricultural products because they could control the money. It might also be due to them being mobile and experienced with the outside world, whereas women generally had restricted mobility.

When 'women's involvement in outside work' was cross checked with 'income' of the families, it was found that men in high income group expected their women to be involved in household chores whereas in low income group, men expected the women to share the burden of

working outside (in the field). Cross tabulation with 'type of family' revealed that in nuclear families both men and women were involved in agricultural and in outside work, when compared to joint families.

Cross tabulation of 'women's involvement in outside work' with 'caste' revealed that women in 'general caste' were more involved in tasks outside of their household activities like going to village and city market for shopping, selling agricultural products, cutting/harvesting the yield.

4.1.3. Decision making in the Family

4. 1.*3.1. Family meeting for decision making*

Respondents were asked "Do family members meet before taking any decision?" 93.64% respondents answered affirmatively which signifies that majority of participants were taking decisions consulting their family members. This variable was cross tabulated with other socio demographic variables to understand the influences and trends.

Cross tabulation of 'decision making process' with 'the sex of head of family' revealed that in male headed families 95.9% of the respondents said that their family members met before taking any major decision, where as in female headed families it was only 76% who consulted the family members before taking any major decision. Same was cross tabulated with 'caste of the respondents' which revealed that 98.2% of tribal group always met before taking any major decision in the family; where as it was 88.8% in case of SC; 93.5% for the OBC and 92.6% for general caste group. Overall, it can be concluded that families tend to discuss with other family members before taking any major decisions concerning the family.

The responses when cross tabulated with 'religion' revealed that majority of them in all the four religious groups consulted the family members before taking important decisions concerning their families (100% - Sarna and Christian, 91.5% Hindu and 94.4% Muslim).

When 'the decision making process in the family' was cross tabulated with the 'nature of their livelihood', it was revealed that families having secured source of livelihood like salaried job, pensioners and professionals always consulted the family members before taking any important decision. Cross tabulation with 'monthly income' also supported the previous finding that higher the family income, more consultation with the other family members before taking important decisions.

4.1.3.2. Women's participation in family meetings

To understand women's participation in family meetings, the heads of the families were asked "Do women participate in the family meeting?" Majority (89.5%) of the heads of the families said that women participate in family meetings; and 4.14% did not consider women as important members to be consulted.

When the same was cross tabulated with the 'sex', it was found that 8% of female headed families and 10.2% of male headed families did not involve females in the decision making process. This indicates that even though female heads the family, she was only a nominal head and man remained the functional head.

When the 'female involvement in decision making' was cross tabulated with 'caste' it was found that tribal heads of families involved their women actively in the decision making process when compared to 'SC', 'OBC', or 'General caste' groups. Among the tribal groups, 97.1% of the families involved women family members in the decision making process, whereas among OBC it was 89.1%, SC 87.7%, and for the 'general caste group' it was 85.7%. In general, most families irrespective of their castes, involved women family members while taking family decisions.

When cross tabulated with 'religion', Christian and Sarna followers consulted women family members in the family meetings.

'Women's participation in family meetings' when cross tabulated with 'education of the head of the family' it was revealed that education did not have influence on the perceptions of the heads of the family in involving women in family meetings. Percentage was more or less the same for all educational groups.

When 'women's participation in family meeting' was cross tabulated with 'income', it revealed that people having regular income as salary and pension involved women in family meetings. Same was not seen with the agricultural and daily wage laborers. The results also indicated that in those families with higher income women's participation in family meetings and in the decision making process appeared to be better.

Cross tabulation of women's participation in family meetings and the 'type of families' revealed that more women (91.4%) participated in family activities in the nuclear families and less participation (86.9%) was seen in joint families.

4.1.3.3. Making final decisions

In order to understand the final authority in decision making, heads of the families were asked "Who takes final decision?" Though majority of the heads of families felt the need for women's participation in family activities and decision making, the final decision making was still with men (61.36%) in most families. In lesser number of families (14.5%) females took the final decision. In about one sixth (14.5%) of families the decision was taken jointly. One tenth (9.64%) of them did not respond to this question.

When it was cross tabulated with 'sex of the head of the family' it was found that in 52% of female headed families' woman took the final decision, whereas in 9.7% of the male headed families, woman took the final decision.

Cross tabulation of 'final authority on decisions made' with 'the caste of the families' revealed that families belonging to OBC caste did not allow their female family members to take the final decision. A small percentage of families belonging to OBC (9.68%), SC (22.2%), ST (16.4%) and General caste (14.8%) seemed to have allowed female members to take the final decision related to household matters.

Cross tabulation of 'the final authority in decision making' with 'religion', with 'education', with 'livelihood', did not show any difference between groups and within groups, indicating that the heads of families more less had given similar responses in all the four religious groups; six education groups and seven occupational groups.

When the same was cross tabulated with the 'income', it was found that families with income below Rs 6000 consulted their female counterparts before taking decision and also allowed them at times to take the final decision; whereas in families with income above Rs 6000, it was mostly men who took the final decision. Most families reported consulting the female members on issues related to family. Consulting on the issues meant sharing responsibility but not giving the power.

'The final decision making power' when cross tabulated with 'the type of family' it was found that in nuclear families a higher percentage of females (19.4%) took the final decision when compared to women in joint families (7.1%). In conclusion, it was evident that even though all the heads of the families recognized the need for consulting females before taking any decision, in reality the final decision was taken by men in the families. Men probably considered themselves responsible for the outcome of their decision making or they held the power of decision making with them.

4.1.3.4: Decision on the number of children to have

A question was asked regarding "Who takes decision on the number of children to have for the family?" Almost three fifths (59.09%) of the heads of families said that both husband and wife took the decision jointly on the number of children. About a sixth (15.9%) of the heads of families said females took the decision on the number of children they should have. In 25% of the families men took the decision with regard to the number of children.

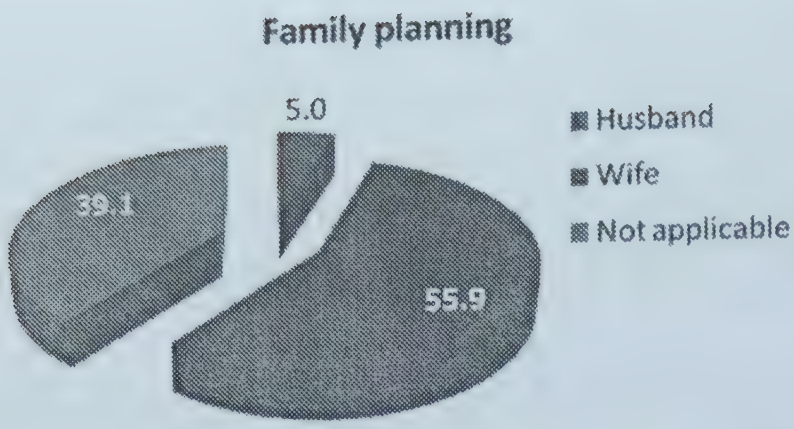
The religious influence was seen among Muslims. Woman was not allowed to take decision on the number of children partly because of the religious beliefs and partly because men wanted to have a say on the matter.

Level of education of the couple seemed to have influence on the need and recognition for the joint decision with regard to the number of children. In non-literate group 61.9% of them took a joint decision, where as it was 80% in higher secondary educated, and 83.3% in graduates group.

Thirty five heads of families said females in their family took the decision on the number of children. Families having regular income in form of salaries, pensions etc took joint decision about the number of children. Out of the 35, 29 respondents (82.86%) were from agricultural background. It was found that the 35 respondents who said female took the decision on the number of children, all of them belonged to lower income group with less than Rs.6000 as monthly income. In families with the income above Rs.6000, more joint decisions between the couple were seen.

4.1.3.5: Decision regarding Family Planning operation for men/women

To understand the perception with regard to "who would undergo / have undergone family planning surgical intervention between the couple", 55.9% said their wife would or had undergone family planning operation. Only 5% of men said that they should undergo surgery. The present study brought out clearly the prevailing cultural practice that women should undergo Family Planning operations.



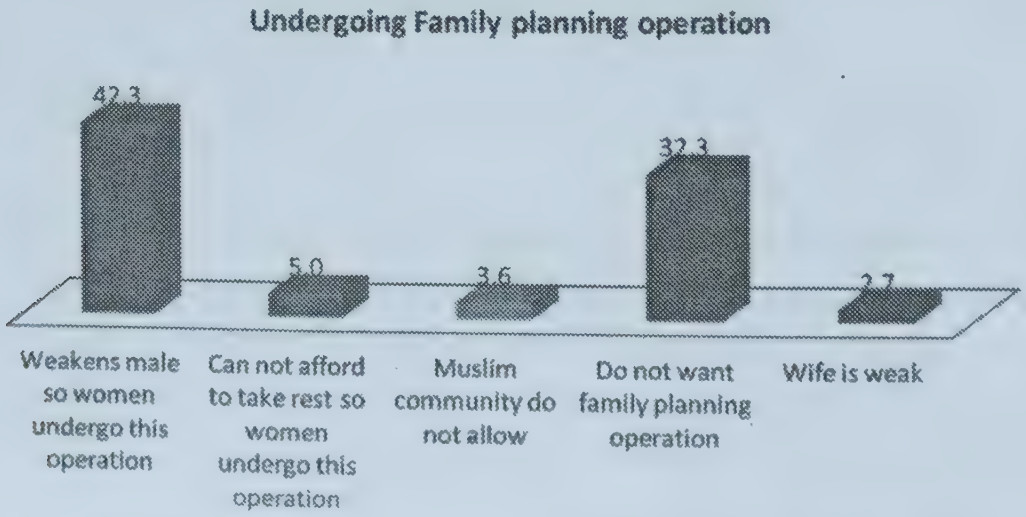
[Graph 3 Family Planning operation undertaken by men and women]

The heads of families gave different reasons for women rather than men undergoing the family planning operation.

Table 5: Distribution of respondents according to reasons for family planning operation undertaken by women

Responses	Total No respondents	Frequency	Percent
Weakens male, so women undergo this operation	220	93	42.3
Men cannot afford to take rest so women undergo this operation	220	11	5.0
Muslim community does not allow	220	8	3.6
Do not want family planning operation	220	71	32.3
Wife is weak	220	6	2.7

Among the 220 respondents, 42.3% believed that this surgical intervention weakened men. As men were the bread earners, working outside the home and engaging in hard labor, undergoing family planning surgical intervention would affect their working potential and hence the family income. The heads of the families felt that women should undergo this surgical intervention since they stayed at home and had less strenuous work. 32.3% of heads of the families did not want to follow family planning.



[Graph 4 – Reasons for family planning operation for women and men]

The prevailing belief that 'women rather than men should undergo family planning surgical intervention was held not only by men but women also justified the same. To quote one voice, Mrs GD said, "if men undergo family planning surgery it will decrease their vigour and vitality. My husband has to do strenuous work, that's why I underwent the operation".

Five percent of heads of the families said that men cannot afford to take rest after the surgical intervention because they are the main earner of the family. To quote, Mr SY said, "My wife underwent this operation because the person has to take rest for six months after operation. As husband works outside, he cannot take rest for six months."

Muslim respondents said that practicing family planning in their community is a taboo. To quote, Mr FA said, "We in the Muslim community do not undergo these types of operations."

A few were of the view that women want to find solution to problems related to their reproductive system, so they preferred to undergo the family planning surgery. Mr RR said, "Women want to stay healthy, that's why they prefer to undergo this operation."

These bring to the fore the lack of understanding and insensitivity on the part of men towards women's load of work and also their needs.

The cross tabulation of practice of 'family planning surgical intervention' and 'religion' revealed that heads of the families belonging to Muslim, Christian and Sarna religion did not want to undergo this operation.

The results also indicated that educational qualification of the heads of the family did not have influence on the prevailing cultural practice in this regard. Most of the educated male seemed to believe that family planning surgery should be undertaken by women, as this surgery made men weak.

The present research study revealed that women were not the sole decision makers of child-bearing. Even the basic right of having control over one's body was not fully with the women. Women justifying women undergoing family planning operation cannot be interpreted that they are the decision makers. They seemed to go along with men's perceptions either because they were not aware, or they had little or no power in terms of control over important family decisions.

4.1.3.6. Decision regarding visiting a doctor by women

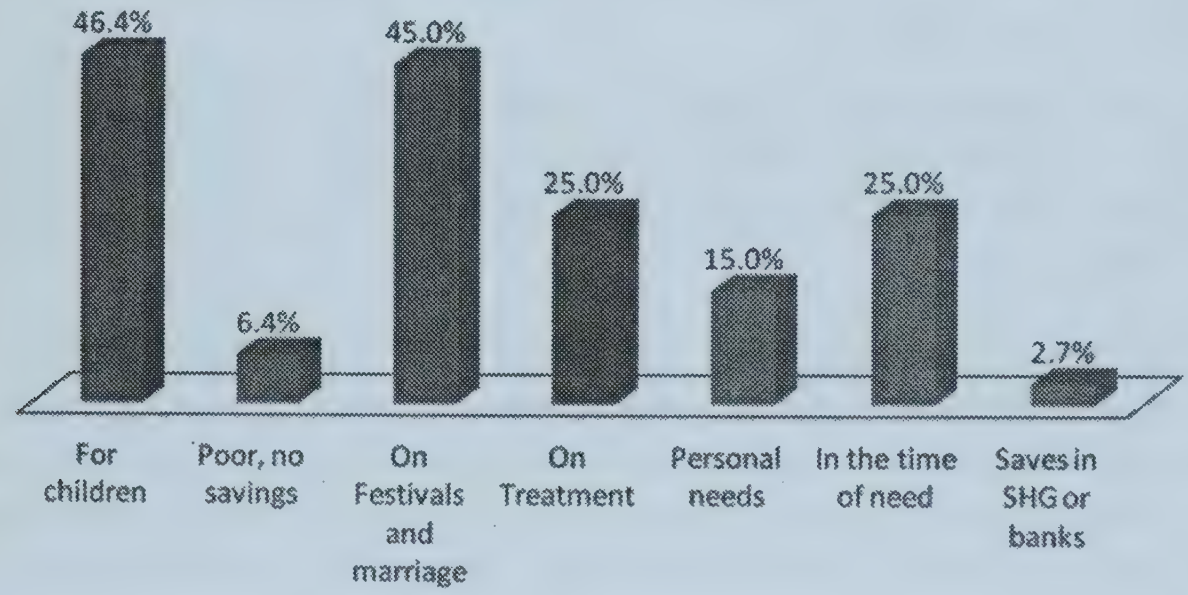
Responses to the question "Is woman free to visit a doctor on her own for consultation on her health condition?", showed that 93.1% of the heads of the families said that woman could decide on her own about consulting the doctor. When asked "Does the woman require permission to visit the doctor?" 74.6% of the heads of the families said women discussed with men and took permission for consulting the doctor. When another question "Whose permission do they seek before going to the doctor?" was asked, nearly four fifths of the heads of the families (79.8%) responded that generally women sought permission from father/ son/ brother/ husband. This indicates that male members took decisions concerning women's health and well being. Only 15.24% sought permission from their mother and 4.87% respondents took permission from in-laws.

4.1.3.7. Decision regarding spending money in the household

The heads of the families responded to the question "Who decides how the money would be spent?" The results indicated that 49.55% of the heads of the families confirmed that it was the male members in the family who decided on how the money would be spent. 33.64% of the respondents said that both male and female members decided on how money would be spent. About one fifth (18.62%) said that women decided on how money would be spent for various family needs.

Table 6: Pattern of spending by women in the household

Responses	Total No respondents	Frequency	Percentage
For children	220	102	46.4
On Festivals and marriage	220	99	45.0
On Treatment	220	55	25.0
At the time of need	220	55	25.0
Personal needs	220	33	15.0
Saves in SHG or bank	220	6	2.7
Poor, no savings	220	14	6.4



[Graph 5 – On whom / what, women spend their savings]

When 220 respondents were asked about spending the money women saved, the responses as shown in the table and in the bar graph indicate that much of women's savings were spent on meeting the needs of children like buying books, pencil, clothes and sweets. They also spent on festivals and marriages. One fourth (25%) mentioned that they spent their savings for health needs and treatment; and the same percentage also said that they used their savings for emergency needs. This shows clearly that women spent their savings mostly on the family needs and very little on themselves.

A small percentage (2.7%) saved money either in the bank or in SHG. 6.4% of them did not save at all as they were very poor.

When 'pattern of decision on spending money' was cross tabulated with 'sex', it was found that in female headed families 52% (13 out of 25 respondents) of the females decided on 'how to spend money in their family'. Two fifths (40%) said that both male and female together decided on the spending. Whereas in male headed families, 54.87% of the males decided on 'how to spend the money in the family'; and in 32.8% of the families, the couple together decided on the spending. About one half of men and one third of women seemed to have some say in how the family money was spent. It was not entirely the decision of men alone.

In Sarna and Christian religions, more females decided on 'how to spend the money' than their Hindu and Muslim counterparts.

The results also indicated that educated spouses allowed their female members to decide on 'how to spend the money'. The cross tabulation of 'pattern of decision on spending money' and 'income of the family' indicated that 37 heads of families said that females took decision regarding spending money in the family. They belonged to the low income group of less than Rs 6000 per month. This also indicated that in low income group more females had control in financial matters than in higher income group, because women were also earning. In nuclear families more number of women (23.1%) had their say in the financial matters than women of joint families (7.1%). Overall the spending pattern indicated that mostly men decided how to spend money. Whenever women had a small amount, they generally spent it on others and on family needs, and only 15% of them spent it on themselves.

To conclude, in the decision making regarding finances in the family, it was found that in religious groups like Sarna and Christian families and in low income families the female members seemed to play a significant role in financial matters. This may be because of their contribution to the family income and the supporting role played by them in agriculture. The tribal group who followed Sarna religion appeared to have different norms governing their lives which are much more enabling and empowering women.

4.1.4. Access to and Control over resources for men and women

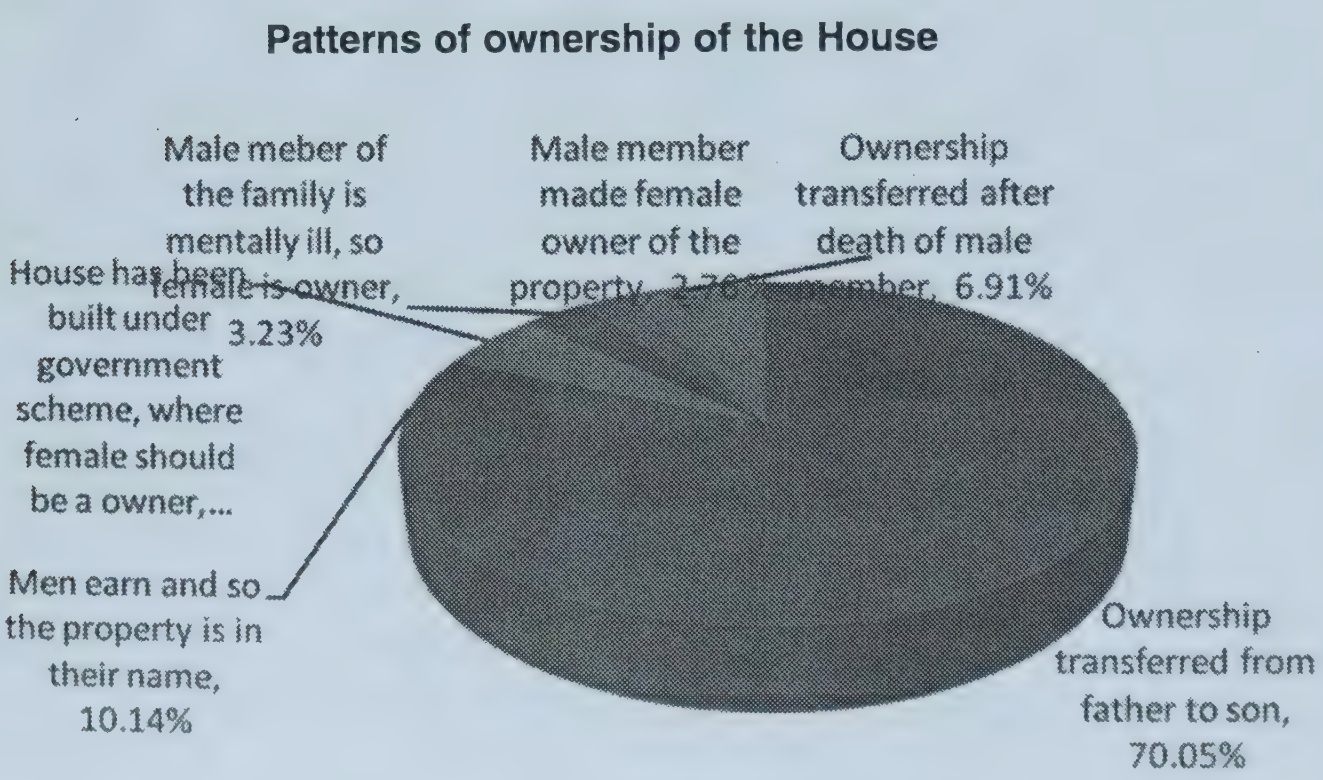
The resources included in the present study were the house, land, cattle, vehicles and bank accounts. These are the basic resources for living with some comfort. The pattern of access to and control over them can bring out the status enjoyed by men and women.

4.1.4.1. Ownership of house:

The heads of the families were asked "Who owns the house?" Out of 217 respondents who had at least one house, in 174 families (80%), the owners were male members. Nearly 18% said that women owned the house and 1% said it was owned by both the spouses. Men owned the house in majority of the families for two reasons - the houses were inherited from forefathers or they were bought by them with their own earnings. Women were owners of the house under four major life situations: (a) ownership was transferred from husband to wife after his death, (b) when the male member was mentally ill, (c) when the house was constructed under a government scheme meant for women and (d) when male member made female member as owner of the property. In only 3 cases, both male and female members of the household were joint-owners of the house.

Table 7: Patterns of ownership of the house and reasons for ownership by men/ women

Owner of the house	Why they are owners?	Total no of respondents	Frequency	Percentage
Male	Ownership transferred from father to son	217	152	70.05
Male	Men earn so the property is in their name	217	22	10.14
Female	House has been built under government scheme, where female should be the owner	217	12	5.53
Female	Male member of the family is mentally ill, so female is the owner	217	7	3.23
Female	Male member made female the owner of the property	217	6	2.76
Female	Ownership transferred after death of male member	217	15	6.91



[Graph 6 – Reasons behind gender specific ownership of the house]

Interestingly in female headed families, a little more than half (52%) of the heads of families said female members were the owners of house, whereas in male headed families, only one eighth (13.3%) said that female members were the owners. Most of them were aged and widows. Property was transferred from the husbands after their death. In the secured income category of people getting regular monthly income as salary or pension, none of the female members owned a house; whereas in agriculture and daily labor groups, more women had a house in their names.

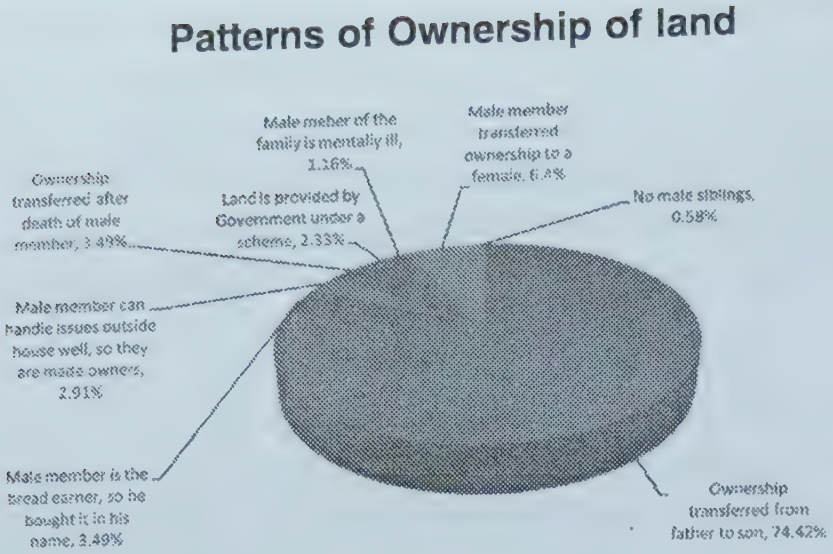
4.1.4.2. Ownership of land

In continuation to this question, the heads of families were asked on ownership of land, cattle, having a bank account and a vehicle (two-wheeler). 172 families had land for cultivation and a house to live in. In 139 families men were the owners of land, and women were the owners in 24 families. In only 9 families both men and women were the owners of land. The norm of patriarchal community is that men should own the property. In most instances ownership was getting transferred from father to son. If the property was bought from their savings, men preferred to buy in their name, which is an accepted norm in a patriarchal society. There is a ray of hope visible in that at least the aged and widowed women had the land in their names.

Women owned the land in 24 families, mainly because ownership was transferred from the husband to wife after his death; when her husband was mentally ill or when the land was provided under any government scheme which required women to own the given land. There were few instances when male member of the family had purchased the land in the name of the female member. This shows that there is some access to the resource of land by women. (It would be interesting to look at who actually controlled the land owned by women!!)

Table 8: Patterns of land ownership and reasons for ownership by men/women

Owner of the land	Why they are owners?	Total no of respondents	Frequency	Percentage
Male	Ownership transferred from father to son	172	128	74.42
Male	Male member is the bread earner, so he bought it in his name	172	6	3.49
Male	Male member can handle well the issues outside the house, so he is made the owner	172	5	2.91
Female	Ownership transferred after the death of male member	172	6	3.49
Female	Land is given by the Government under a scheme requiring women to be the owners	172	4	2.33
Female	Male member of the family is mentally ill	172	2	1.16
Female	Male member transferred ownership to a female	172	11	6.40
Female	No male sibling	172	1	0.58



[Graph 7 – Reasons behind gender specific ownership of land]

The picture given above clearly demonstrates that a large number of men inherited their share of property from their fathers. This is another proof of the norm of the patriarchal society. From the pie chart it is evident that men had access to and control over the family property. Women owned the property only when she was enabled by measures such as the government schemes requiring women to be the owners. Again, when there was no male child in the family, women got her property share transferred from their parents. This is a slight variation to the patriarchal norms to the advantage of women, as traditionally any male progeny of the joint family would have inherited the property. A few reported that male members could handle well the issues outside the house, hence they were made the owners. These factors bring out the restricted boundaries for women.

4.1.4.3. Ownership of cattle

Further, heads of the families were asked "Who owns the domestic animals at home such as cows/ bulls/ hen/ cock/ sheep/ goat etc". It is an interesting fact that 77.7 % (171 out of 220) said males owned the cattle. Out of 171, 124 heads of the families said ownership of cattle was with men because only men dealt with selling or buying them. They were of the view that women had little or no knowledge on such matters. In patriarchal communities marketing is the prerogative of men. This again is due to restricted mobility of women in those communities, which also restricts them from gaining knowledge on such matters.

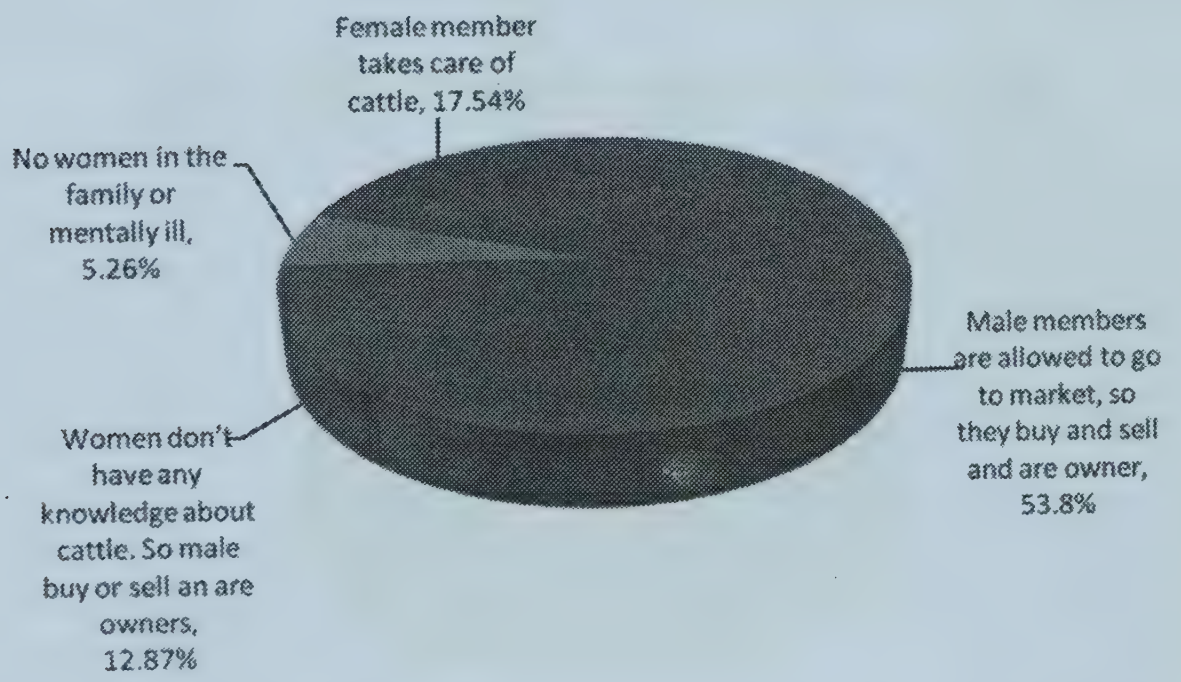
In 34 families, women were owners of cattle because they took care of them as male members had migrated to other places for earning an income. Only five families reported that both men and women owned cattle. When the responsibility of looking after the cattle was looked at, it was found that generally women were expected to graze the cattle and take care of them. When it came to marketing the products and/ or selling cattle, men took control of the situation.

In nine families the male did the buying and selling of cattle even when the owners were females. It showed that money transaction was controlled by male members even though the resource ownership was with the female. Thus, women appeared to be only nominal owners of the cattle.

Several families stated that women were not allowed to do the marketing. Women too were not keen in taking up this responsibility as it meant traveling outside their homes. This again confirmed the influence of patriarchal society where female had restricted movement outside their home and these boundaries were kept alive

Table 9: patterns of ownership of cattle and reasons for ownership by men/ women

Owner of Cattle	Reasons for ownership	Total no of respondents	Frequency	Percentage
Male	Male members are allowed to go to market, so they buy and sell and are owners	171	92	53.80
Male	Women don't have any knowledge about cattle. So male buy or sell hence are owners	171	22	12.87
Male	No women in the family or woman is mentally ill	171	9	5.26
Female	Female member takes care of cattle	171	30	17.54



[Graph 8 – Reasons behind gender specific ownership of cattle as a resource]

In response to the reasons for owning cattle by men and women, about a third (29.8 %) of the heads of the families felt that it was because of the cultural practice of women not expected to visit market for buying and selling as they should be at home to take care of the household activities. The norm specifying the expectation that men should go to market for buying and selling cattle decided on its ownership. 23.4% of the heads of the families felt it was male members who earned and had the capacity to assess and buy cattle; hence the ownership was with them. About one eighth (13.5%) of the heads of the families felt that men had better knowledge about cattle than women; hence men could buy good breed, hence were the owners. Those heads of the families who claimed that women were the owners of cattle said that women generally were assigned the responsibility of caring for the cattle so they could be treated as owners. A small percent (5.8%) of the heads of the families said that male members often went away in search of livelihood, and in their absence the female members were

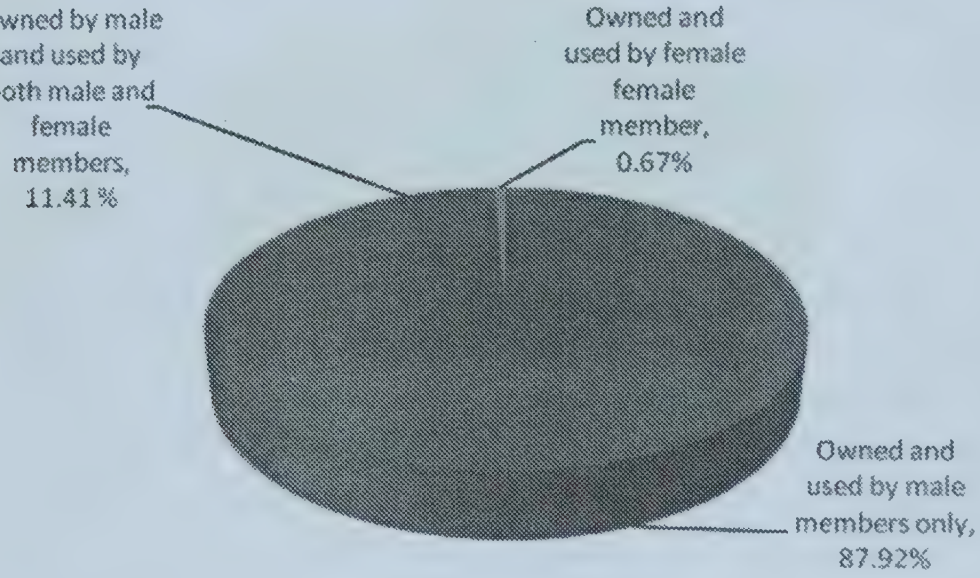
buying and selling cattle and hence were considered owners. Only 8.8% of respondents said that both men and women were the joint owners of cattle. A small percent (6.4%) of the heads of the families said that due to the absence of a woman to manage the cattle at home, men took the ownership of cattle. In conclusion, the load of caring for the cattle was the responsibility of women. It is clear that as male owned properties, women were given the responsibility to manage and maintain them.

4.1.4.4. Ownership of vehicles

Table 10: Pattern of ownership and use of vehicles by men/women

Owner of two wheelers	Total No. of respondents	Frequency	Percentage
Male and used by male members only	149	131	87.92
Male and used by both male and female members	149	17	11.41
Female and use by female member	149	1	0.67

Patterns of Ownership and use of Two wheelers



[Graph 9 – Gender specific ownership and use of two wheelers]

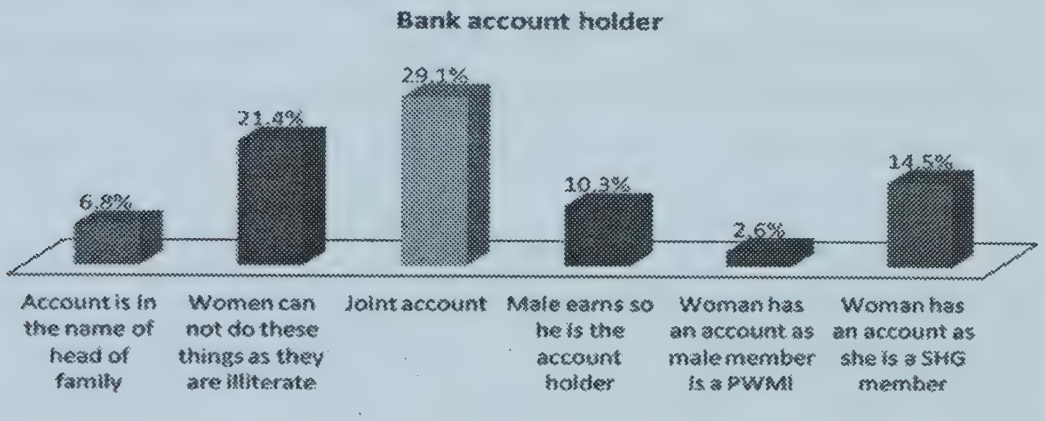
When heads of the families were asked about owning two-wheeler, it was found that 149 families out of 220 owned a two-wheeler, out of which 148 belonged to men. The two wheelers included motor cycles and bicycles which were used mostly by men. Though 17 families (of the 148) reported use of bicycles by both men and women, the ownership was with men. Only in one family the bicycle was owned by the woman and used by her.

4.1.4.5. Bank accounts (Ownership of money as a resource)

In order to understand the ownership of their savings in bank and post office, the heads of the families were asked "Does the family have an account in bank or post office?" to which 53.2% out of 220 respondents gave an affirmative response. They were further asked," Who holds the account?" and the reason for the same.

Table 11: Reasons for holding Bank accounts by men/women

Responses	Total No. of respondents	Frequency	Percentage
Joint account	117	34	29.1
Account is in the name of head of family i.e. man	117	8	6.8
Male earns so he is the account holder	117	12	10.3
Women cannot do these things as they are illiterate	117	25	21.4
Woman has an account as the male member is a person with mental illness	117	3	2.6
Woman has an account as she is a SHG member	117	17	14.5



[Graph 10 –Gender specific holding of bank account]

Nearly one third (29.1%) of heads of the families said that they had a joint account, as they felt this would increase the habit of saving in both the husband and wife, and wife could withdraw money in the absence of husband. About one fifth (21.4%) heads of the families said that male members handled bank transactions as women were illiterate and could not deposit or withdraw money from the bank. About a tenth (10.3%) of the heads of the families expressed that the male earned and saved hence he should have the account in his name.

Almost one sixth (14.5%) of women had bank account as she was a member of a Self Help Group. A small percentage (6.8%) of the families had their heads as account holders in the bank.

It is clear that in general, owning, accessing and control of resources were the prerogative of men. Women were managing the resources in the absence of male members in the family. Irrespective of whether it is land, house, cattle or vehicle men in the family were the generally accepted owners and managers. There are exceptions, but the reasons for such exceptions still proved that men enjoyed the primary position and women the secondary position.

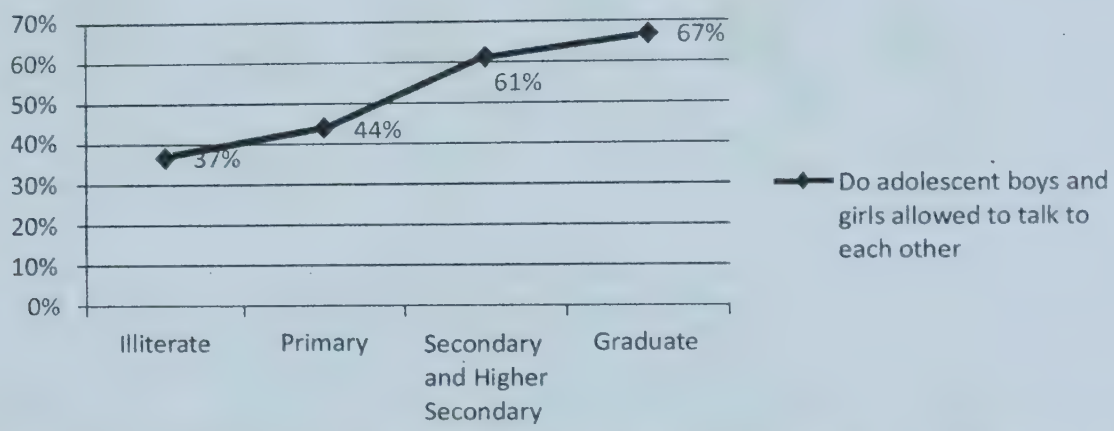
4.1.5. Social status of men and women

4.1.5.1. Interaction between boys and girls

To understand the perceptions regarding friendship between boys and girls, the heads of the families were asked "Are adolescent boys and girls allowed to talk to each other?" In response, 51.86% of the heads of the families said that adolescent boys and girls were not allowed to talk with each other.

When it was cross tabulated with 'religion', it was found that Christians were more liberal towards allowing adolescent girls and boys to talk to each other. Only 33.3% of Christians did not allow; 44.4% of Sarna respondents and 53.2% of Hindu respondents were not for free interactions of adolescent boys and girls.

When the same was cross tabulated with 'the educational background of the head of family', it was observed that 36.6% of non-literates, 43.8% of primary educated, 53.3% of higher secondary educated and 66.7% of graduates felt that adolescent boys and girls should be allowed to talk. This shows that educational level of the heads of the family did have an effect on their perception in this regard. With increase in the educational level there was increase in the percentage of heads of families perceiving the need for allowing interactions between adolescent boys and girls.



[Graph 11 - Educational background of heads of family Vs perception of the people towards allowing adolescent boys and girls to talk with each other]

4.1.5.2: Perceptions regarding the marriage age of boys and girls

To understand the perceptions of families regarding marriage age of boys and girls in their community, the heads of the families were asked about the age of marriage for boys and girls in vogue in their community. A majority (83.6%) of head of the families felt that boys should get married between 18 – 23 years; and 66.36% of them said that girls should be married between the ages of 18 – 23 years. Almost one third (32.27%) of the heads of the families felt that a girl should get married between the ages of 10 – 17 years.

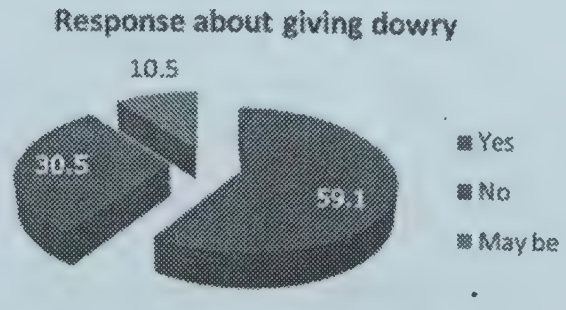
When the same was cross tabulated with 'the caste of the head of the families', it was found there was prevalence of child marriage practices in SC (55.5%), OBC (38.7%), 'general caste' (18.5%) and ST (9.09%) groups. The low prevalence of 'child marriage practice' among schedule tribe was because women were mostly bread earners and did all household work as well. They followed a system wherein boys should pay `dowry' to girl's father and this caused delays in their marriages. The statistical analysis showed that 'educational background', 'religious practices' and 'monthly income' of the families did not have influence on the prevailing practice of early marriage of girls.

4.1.5.3. Practice of giving/taking dowry at the time of marriage

When respondents were asked "Will you pay/ have paid dowry?" Almost three fifths (58.64%) of respondents said "yes". When they were asked "Will you take or have taken dowry?" more than half (53.6%) of the respondents said that they would or had taken dowry.

Table 12: practice of giving dowry at the marriage of girls

Response	Frequency	Percentage
Yes	130	59.1
No	67	30.5
May be	23	10.5

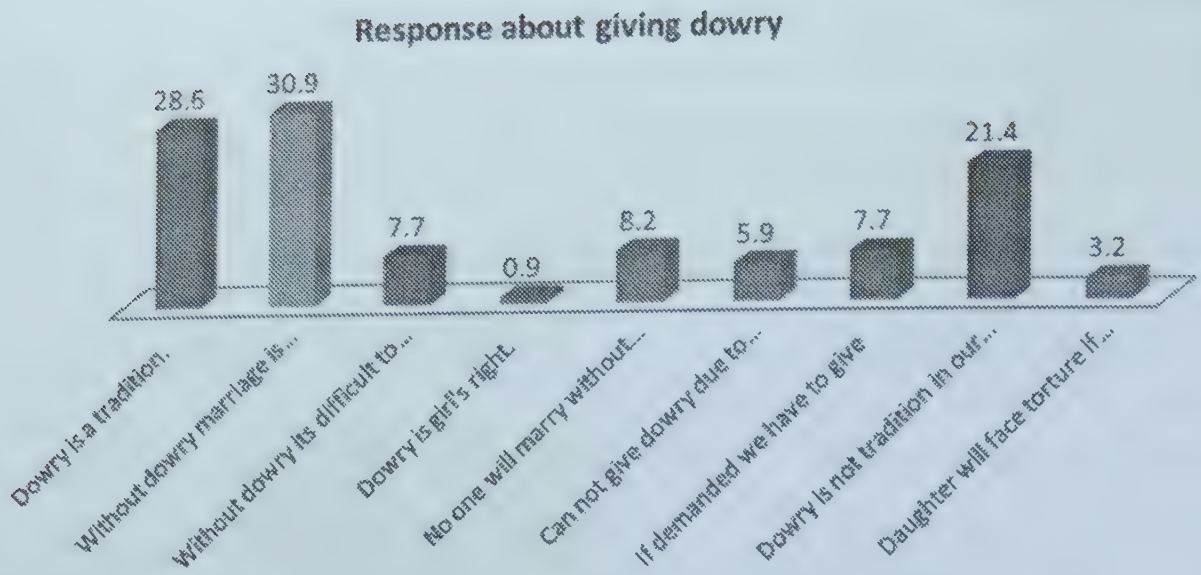


[Graph 12 – practices of families in giving dowry for their girls

The heads of the families were asked "Would they give dowry in their daughter or sister's marriage?" Majority of them (59.1%) said that they would give dowry to their daughter or sister's marriage. Only 30.5% said that they would not give dowry; and 10.5% of them were uncertain but said they would not mind giving if they have to.

Table 13: Reasons for giving dowry

Reasons for giving dowry	Total No respondents	Frequency	Percentage
Dowry is a tradition.	220	63	28.6
Without dowry marriage is impossible	220	68	30.9
Without dowry its difficult to get a good life partner	220	17	7.7
Dowry is girl's right.	220	2	0.9
No one will marry without dowry	220	18	8.2
Can not give dowry due to poor financial condition	220	13	5.9
If demanded we have to give	220	17	7.7
Daughter will face torture if she does not take dowry	220	7	3.2
Dowry is not the tradition in our tribal community	220	47	21.4



[Graph 13 – Reasons for practicing dowry system]

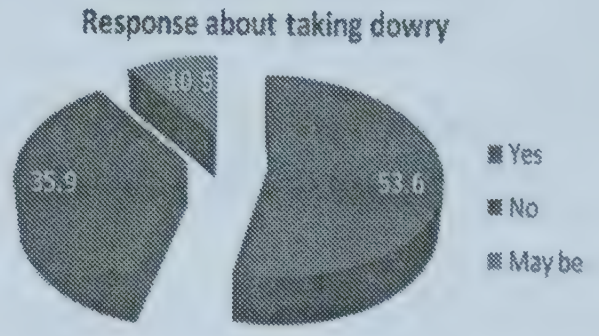
When asked about the reason(s) for practicing dowry system in their community, 68 heads of the families said that without giving dowry marriage was impossible and it was difficult to get a good life partner for their daughters or sisters. To quote the opinion of Mr TY, "As per our culture and tradition it is mandatory to give dowry in marriage. Without giving it is difficult to get a good boy from a good family". There were responses like "they did not want to give dowry, but if demanded they have to otherwise no one will marry their daughters or sisters."

Other reasons were "if dowry is not paid their daughters or sisters would suffer as they may be subjected to torture in the in-laws family. More than one fourth (28.6%) of the heads of the families felt that "dowry is a tradition in the society, hence should be followed." Two respondents felt that "it is the right of the girl to take dowry." To quote Mr MK, "Daughter stays in their in-laws house after marriage. As they do not have right over her parental property, it is to be given in the form of dowry."

Tribal did not practice the system of dowry in their culture. Thirteen heads of families or 5.9% said "they could not give dowry to their daughters and sisters due to their poverty, but if they had the money they would also give."

Table 14: Practice of taking dowry at the marriage of Boys

Prefer to take dowry	Frequency	Percentage
Takes dowry	118	53.6
Does not take dowry	79	35.9
May be	23	10.5

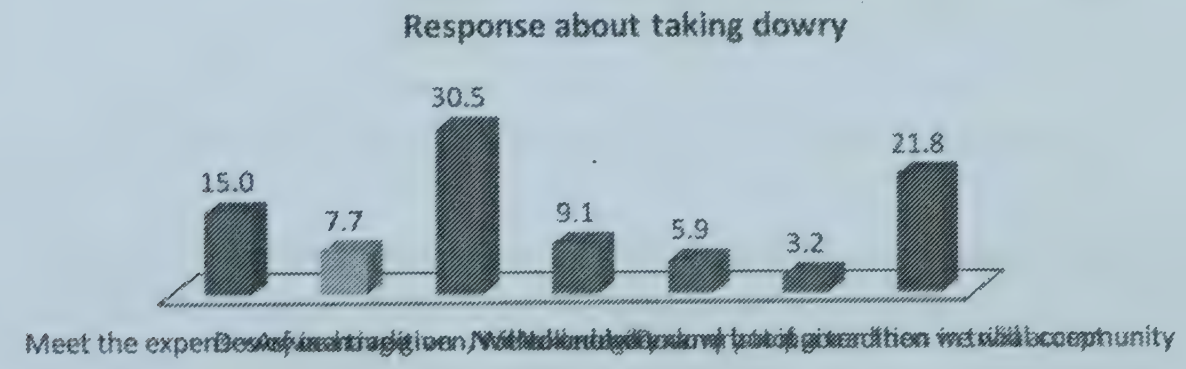


[Graph 14 – taking dowry at the marriage of boy}

Over one half of the heads of the families said that they would take or had taken dowry for their son's and brother's marriage.

Table 15: Reasons for taking dowry

Reasons for taking dowry	Total No respondents	Frequency	Percent
Meet the expenses of marriage	220	33	15.0
Dowry is a tradition	220	17	7.7
As we have given, will also take	220	67	30.5
Not take dowry	220	20	9.1
No one gives dowry to poor	220	13	5.9
We will not demand but if given we will accept	220	7	3.2
Dowry is not a tradition in tribal community	220	48	21.8

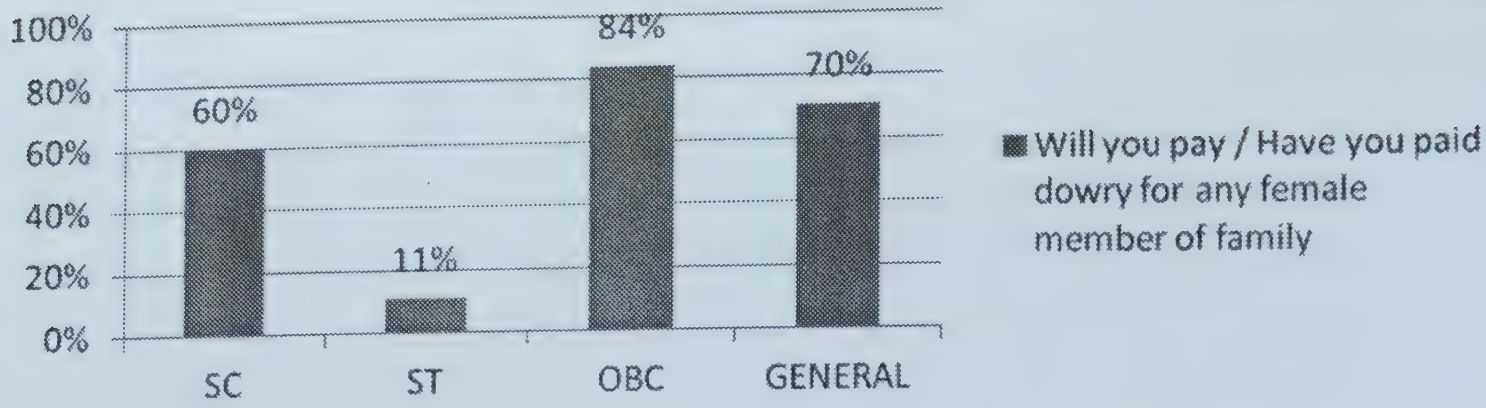


[Graph 15 – Reasons for taking dowry]

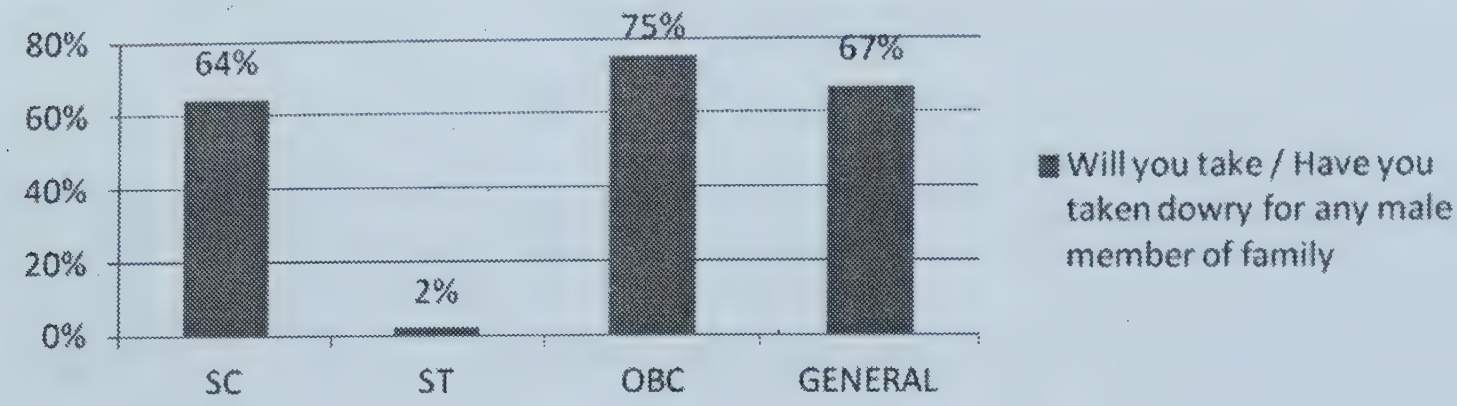
The heads of the families justified their perception about taking dowry by saying that it was a compulsion. They explained that the money is taken as the groom's party also incurred lots of expenses and it is difficult to meet those expenses by themselves (15%). To quote Mr CY, "I demanded dowry in my son's marriage as one needs to spend money in marriages.

About a third of the respondents stated that they would take or had taken dowry just because they had given or had to give dowry for their daughters or sister's marriage. About one fifth of the families in the sample, the tribal group said they would not take dowry as it was not the practice in their community. A small percentage (3.2%) of the heads of the families said that they would not demand but would accept if given.

The cross tabulation of 'the practice of giving/taking dowry' and the 'caste groups' revealed that system of giving/taking dowry was highly prevalent among OBCs (83.7%) They stated that they would give or had given dowry. Around three fourths (75.3%) also said they would take or had taken dowry. Next in order were 'General caste' and SC groups. As already stated, ST group did not follow the system of giving or taking dowry in their community.



[Graph 16 –dowry system (paid) followed by the caste groups]



[Graph 17 – Dowry system (received) by the caste groups]

When 'practice of giving or taking dowry' was cross tabulated with 'religion', it was found that Muslims followed this custom as 100% of the Muslim heads of the families said they would or had given dowry in the marriages of their daughters and sisters. Nearly nine tenths (88.9%) said they would or had taken dowry in marriages of their sons and brothers. Among Hindus, 70.6% said they had given or would give dowry for their daughters and sisters; and 65.6% said they would take or had taken dowry for their sons and brothers.

Dowry system was almost non existent in Christian and Sarna religious groups. The statistical analysis revealed that giving and taking dowry as a system was in practice in all the families with varied educational levels. The existence of this practice and the financial burden it brought to the family made them feel girls as a burden. In the higher income families earning more than Rs 6000 per month, 85.7% of the head of the families had agreed that they would give dowry for their daughters and sisters; and 57.4% of the heads of the families said they will take dowry for their sons and brothers.

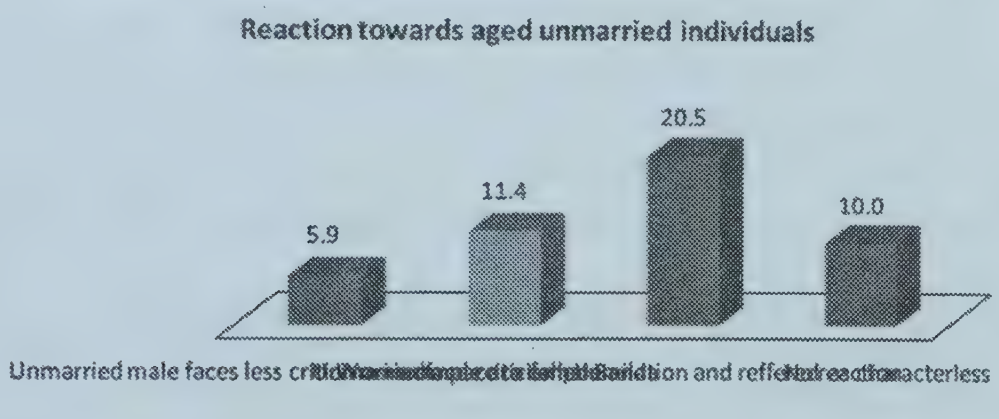
4.1.5.4. Perception regarding 'unmarried' men and women

To understand how they perceive male or female staying unmarried in the communities, the heads of the families were asked "Do people look down the unmarried aged male and female in community?"

About two fifths (40%) of the respondents said "Yes", unmarried males are looked down in society, and when it comes to unmarried female it came down to 20.9%. Many people did not want to talk about this so they avoided by saying "don't know".

Table 16: Perceptions regarding unmarried men and women

Perceptions	Total No respondents	Frequency	Percentage
Unmarried male face s less criticism compare d to female	220	13	5.9
Unmarried male are called Banda	220	25	11.4
Women face criticism, humiliation and referred as characterless	220	45	20.5
No reaction	220	22	10.0



[Graph 18 – Perception towards unmarried men and women]

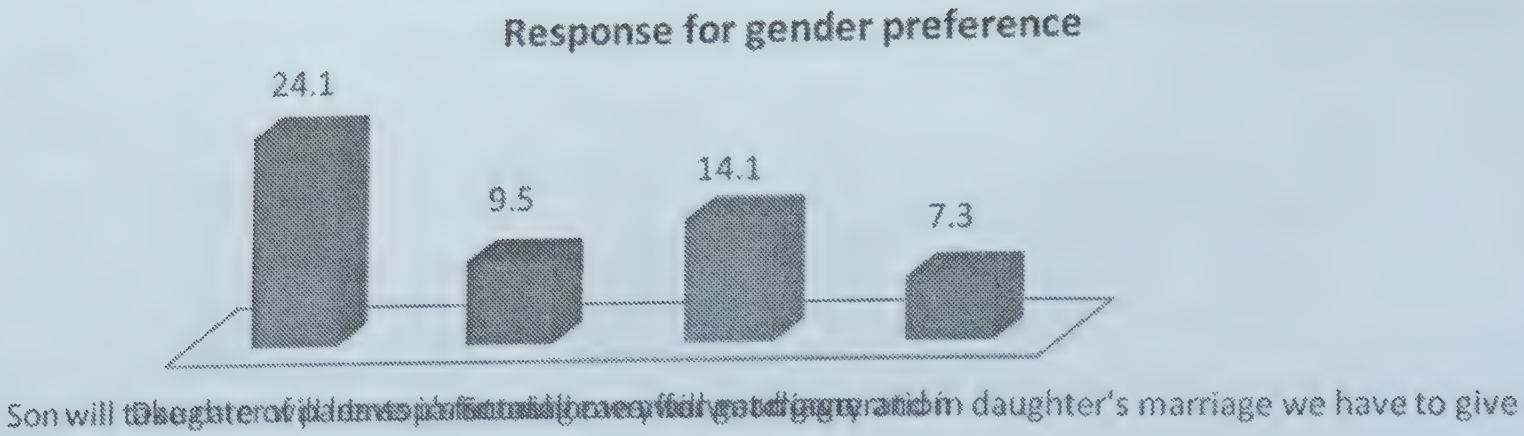
Heads of the families talked about their general experiences. They expressed that women faced lots of criticism and humiliation in the society and they were labeled 'characterless'. Unmarried male was often referred as 'Banda' (i.e. impotent) in the village community (11.4%). A small percentage (5.9%) of respondents felt that unmarried male faced less criticism when compared to an unmarried female.

4.1.5.5. Preference for Male/ female child:

In order to understand sex-preference of child within the family, the heads of the families were asked their preference for male/ female child. Majority of the respondents (89.5%) said they preferred a boy and only a very small percentage (0.9%) said they preferred a girl child.

Table 17: Reasons for male child preference in the community

Reasons for male preference	Total No respondents	Frequency	Percentage
Son will take care of parents in future	220	53	24.1
Daughter will leave parental home after marriage	220	21	9.5
Son will carry forward the generation	220	31	14.1
In son's marriage we get dowry and in daughter's marriage we have to give	220	16	7.3



[Graph 19 – Reasons of male child preferences]

About one fourth (24.1%) of the heads of the families said that they preferred son because "son will take care of parents in future". One eighth (14.1%) of the head of the families said that they preferred son because they will carry forward their generation and towards better economic condition. To quote Mr SP, "Son will carry forward our generation. He would start earning when he is young, which will improve the financial status of the family."

A small percentage (7.3%) of respondents said that they preferred a boy as they could get dowry in his marriage, and in daughter's marriage they need to give. To quote Mr UP, "I would make my son a successful man in life by giving him the best of education. Then only I can get good dowry in his marriage."

A few heads of the families said that they did not prefer daughter as they will leave the parental home after marriage.

4.1.5.6. Celebration of the birth of the male/female child

When the heads of the families were further asked, "Whose birth would they celebrate?" about one half (52.73%) of them conveyed that they would celebrate the birth of a boy, and only 1.36% said they would celebrate the birth of a girl. This shows that a girl child is not welcomed in the family as much as a boy.

4.1.5.7. Education of boys and girls

To understand the perception of the community regarding education of boys and girls, the heads of the families were asked "Do both boys and girls of their family go to school?" 91.3% respondents gave an affirmative answer. On further probing "On whose education they would spend more?" Three fourths (75%) of the heads of the families said that education *of* both boys and girls would be given importance and they would spend on both. About one fifth (18.64%) said that they would spend more on boys' education. Girls would be taken out of the school to assist in the household work. Boys did drop out from school in their mid adolescence, mostly for economic activities and to earn an income.

Though parents were educating their children irrespective of their sex, more boys than girls were expected to continue their studies.

Section 1 B

GENDER PERCEPTION OF FAMILIES AND COMMUNITIES

The results in this section are from the responses of individuals who were administered a check-list of statements related to gender roles in their village communities. The analyses were done according to sex (males and females who responded and also according to the two regions to which they belonged, namely, Lohardaga (Jharkhand) and Gaya (Bihar)

Table 18: Opinion of males and females regarding gender roles in the families

Sl No	Statements	Agree		Disagree	
		Male	Female	Male	Female
1	Husbands and wives should share equally in housework such as cooking, washing dishes, and housecleaning	71 (47%)	80 (50.3%)	80 (53%)	79 49.7%)
2	The husband should have primary responsibility for contributing to the family income	105 (72.9%)	125 (80.6%)	39 (27.1%)	30 (19.4%)
3	Families should spend equal money on the education of daughters as on the education of sons	136 (90.6%)	147 (92.5%)	14 (9.33%)	12 (7.5%)
4	Families should provide equal medical care to daughters and sons	145 (96.0%)	150 (94.3%)	6 (4.0%)	8 (5.7%)
5	Families should provide daughters with as much inheritance as sons, and as much authority over the use of inherited amount	82 (54.3%)	110 (69.2%)	69 (45.7%)	49 (30.8%)
6	Men and women (Husbands and wives) should have equal roles in decisions about investments	136 (90.1%)	147 (92.5%)	15 (9.9%)	12 (7..5%)
7	Men and women (Husbands and wives) should have equal roles in decisions about spending money	133 (88.7%)	149 (93.7%)	17 (11.3%)	10 (6.3%)
8	Virginity is more desirable in a woman than in a man	93 (62.0%)	101 (63.9%)	57 (38.0%)	57 (36.1%)
9	Men's Disloyalty to wife is acceptable	30 (20.0%)	58 (36.7%)	119 (80.0%)	100 (63.3%)

10	Both parents should have equal say in the decision to have a child	135 (90.0%)	144 (90.6%)	15 (10.0%)	15 (9.4%)
11	Women (wives) should have primary responsibility for child care	88 (58.7%)	119 (74.8%)	62 (41.3%)	40 (25.2%)
12	Women (wives) should consider husbands (men) as gods (pathi parmathma hai)	109 (74.1%)	106 (71.6%)	38 (25.9%)	42 (28.4%)
13	It is believed that women should work at home and men should work outside of the home	98 ((66.2%)	127 (79.9%)	50 (33.8%)	32 (20.1%)
14	Men are more capable than women for strong work	115 (76.7%)	118 (74.2%)	35 (23.3%)	41 (25.8%)
15	Women have more medical problems than men	79 (53.0%)	119 (74.8%)	70 (47.0%)	40 (25.2%)
16	Men are always better at making decisions about money	82 (54.7%)	93 (58.5%)	68 (45.3%)	66 (41.5%)
17	Men should have authority in the family	111 (74.0%)	129 (81.1%)	39 (26.0%)	30 (18.9%)
18	Men are more rational than women	69 (46.3%)	97 (62.6%)	8 0 (53.7%)	58 (37.3%)
19	Boys and girls should be treated differently	39 (26.0%)	78 (49.1%)	111 (74.0%)	81 (50.9%)

A total of 310 respondents (151 males and 159 females) from the villages expressed their opinions regarding the roles of males and females (gender roles) in their community. They responded to 19 statements (items) which were considered to be general beliefs regarding the male and female roles in the community. The total responses for the items ranged from 304 to 310. Item 2 had a total of 299 responses and item 12 had a total of 295 responses. Percentages were computed for each item on the basis of total responses as well as the responses of males and females. In general the responses varied with the items.

Predominant male roles brought out by majority of both males and females are:

Item 2 : The husband should have primary responsibility for contributing to the family income (72.9% male and 80.6% female agreed)

Item 12: Women (wives) should consider husbands (men) as Gods (Pati Paramatma Hai). 74% men and about 72% women agreed.

Item 14: Men are more capable than women for strong work; (76.7%males and 74.2% females agreed)

Item17 : Men should have authority in the family (74% males and 81% females agreed).

Predominant female roles brought out are:

Item 11: Women (wives) should have primary responsibility for child care. (58.7% males and 74.8% females agreed)

Item 13: It is believed that women should work at home and men should work outside of the house. (66% of males and 79.9% of females agreed)

Male dominance and female subservience were brought out through more female than male agreeing with reference to the following roles/ behaviour:

Item 1: Husbands and wives should share equally in household work such as cooking, washing clothes and house cleaning. (47% males and 50.3% females agreed).

Item 8 : Virginity is more desirable in a woman than in a man. (62%males and 63.9% females agreed).

Item 9 : Men's disloyalty to wife is acceptable. (20% males and 36.7% females agreed)

Item 15: Women have more medical problems than men (53 % males and 74.8% females agreed).

Item 16: Men are always better at making decisions about money (54.7% males and 58.5% females agreed).

Item 18: Men are more rational than women. (46.3% males and 62.6% females agreed).

Item 19: Boys and girls should be treated differently. (26 % males and 49% females agreed).

Equality of male and female expressed by both males and females in high percentage are seen in the following items:

Item3 : Families should spend equal money on the education of daughters as on the education of sons. (90.6% males and 92.5% females agreed)

Item 4 : Families should provide equal medical care to daughters and sons (96% males and 94.3% females agreed).

Item 5 : Families should provide daughters with as much inheritance as sons and as much authority over the use of inherited funds. (54.3% males and 69.2% females agreed)

Item 6 : Men and women should have equal roles in decisions about investments (90.1% males and 94.3 % females agreed)

Item 7 : Men and women (husbands and wives) should have equal roles in decisions about spending money (88.7% males and 93.7% females agreed).

Item 10: Both parents should have equal say in the decision to have a child. (90% males and 90.6% females agreed)

It is interesting that all the six statements in this category are "what should be" rather than "what is". People in the community seemed to have an understanding of what is ideal and this may not necessarily mean they are accepted by them in day to day practice. It could be taken as an indication of the community starting to think in the direction of equality of men and women. It may be a long way to go when the dominant role of men indicated by the analyses in the categories mentioned earlier.

Gender is an issue in the study area as it is evident from the data presented. Not only male dominance and female subservience were clearly seen, but also the women's acceptance of her secondary status was found in their expressions.

Table 19: Opinion of community members with regard to gender roles in the families according districts.

Sl No	Statements	Agree		Disagree	
		Lohardaga	Gaya	Lohardaga	Gaya
1	Husbands and wives should share equally in housework such as cooking, washing dishes, and housecleaning	82 (65.6%)	69 (37.3%)	43 (34.4%)	116 (62.7%)
2	The husband should have primary responsibility for contributing to the family income	88 (70.4%)	152 (82.2%)	37 (29.6%)	33 (17.8%)
3	Families should spend equal money on the education of daughters as on the education of sons	106 (84.8%)	177 (95.7%)	18 (15.2%)	9 (4.3%)
4	Families should provide equal medical care to daughters and sons	114 (91.2%)	181 (97.8%)	11 (8.8%)	3 (2.2%)
5	Families should provide daughters with as much inheritance as sons, and as much authority over the use of inherited funds	73 (58.4%)	119 (64.3%)	52 ((41.6%)	66 (35.7%)
6	Men and women (Husbands and wives) should have equal roles in decisions about investments	110 (88.0%)	173 (93.5%)	15 (12.0%)	12 (6.5%)

7	Men and women (Husbands and wives) should have equal roles in decisions about spending money	112 (89.6%)	170 (91.9%)	12 (10.4%)	15 (8.1%)
8	Virginity is more desirable in a woman than in a man	68 (54.4%)	126 (68.1%)	56 (45.6%)	58 (31.9%)
9	Men's Disloyalty to wife is acceptable	37 (29.6%)	56 (30.3%)	85 (70.4%)	128 (69.7%)
10	Both parents should have equal say in the decision to have a child	107 (85.6%)	172 (93.0%)	17 (14.4%)	13 (7.0%)
11	Women (wives) should have primary responsibility for child care	54 (43.2%)	153 (82.7%)	70 (56.8%)	32 (17.3%)
12	Women (wives) should consider husbands (men) as gods (pathi parmathma hai)	83 (72.8%)	132 (72.9%)	31 (27.2%)	49 (27.1%)
13	It is believed that women should work at home and men should work outside of the home	83 (68.0%)	142 (76.8%)	39 (32.0%)	43 (23.2%)
14	Men are more capable than women for strong work	76 (61.3%)	157 (84.9%)	48 (38.7%)	28 (15.1%)
15	Women have more medical problems than men	83 (67.5%)	115 (62.2%)	40 (32.5%)	70 (37.8%)
16	Men are always better at making decisions about money	62 (50.4%)	113 (61.4%)	61 (49.6%)	71 (38.6%)
17	Men should have authority in the family	80 (64.5%)	160 (86.5%)	44 (35.5%)	25 13.5%)
18	Men are more rational than women	63 (52.1%)	103 (56.3%)	58 (47.9%)	80 (43.7%)
19	Boys and girls should be treated differently	48 (38.7%)	69 (37.3%)	76 (61.3%)	116 (62.7%)

A total of 310 respondents expressed their opinions on each of the 19 statements regarding gender roles in their community. There were 125 respondents from Lohardaga district and 185 respondents from Gaya district. The responses for the items ranged from 304 to 310 except for item 12, which was only 295.

In the above table, the responses were seen according to the study districts, Lohardaga in Jharkhand and Gaya in Bihar. Variations between districts were looked at. Lohardaga had a larger proportion of tribal population and Gaya had a larger proportion of Backward communities and Scheduled Castes.

There were variations in responses to the items in the two districts. These variations are presented in the following paragraphs organized in terms of the extent of variations.

I. Wide Variations between the two districts were shown by the data for the following items:

Item 1: Husbands and wives should share equally in Housework such as cooking, washing clothes and house cleaning. (65.6% from Lohardaga and 37.3% from Gaya Agreed.)

Item 11: Women (wives) should have primary responsibility for child care (43.2% from Lohardaga and 82.7% from Gaya agreed).

Item 14: Men are more capable than women for physical hard work. (61.3% from Lohardaga and 84.9% from Gaya agreed).

Item 17: Men should have authority in the family. (64.5% From Lohardaga and 86.5% from Gaya agreed).

Though male dominance is evident, gender as an issue appears to be more severe in Gaya than in Lohardaga.

II. Some variations between the two districts were shown by the data for the following items:

Item 2: The husband should have primary responsibility for contributing to the family income. (70.4% from Lohardaga and 82.2% from Gaya agreed).

Item 13: It is believed that women should work at home and men should work outside of the house. (68% from Lohardaga and 76.8% from Gaya agreed).

Item 8: Virginity is more desirable in a woman than a man (54.4% from Lohardaga and 68.1% from Gaya agreed).

Item 15: Women have more medical problems than men. (67.5% from Lohardaga and 62.2% from Gaya agreed).

Item 16: Men are always better at making decisions about money.(50.4% from Lohardaga and 61.4% from Gaya agreed).

Item 18: Men are more rational than women. (52.1% from Lohardaga and 56.3% from Gaya agreed.

The data with regard to the six items also show male dominance in both the districts. But, between the districts, Lohardaga was somewhat more in favour of women than Gaya.

III. The following items require special attention though variation between districts were very small, as they indicated men's superiority over women:

Item 12: Women (wives) should consider husbands (men) as God (Pathi Paramathma Hai) (72.8% from Lohardaga and 72.9% from Gaya agreed).

Item 9 : Men's disloyalty to wife is acceptable. (29.6% from Lohardaga and 30.3% from Gaya agreed).

Item 19: Boys and Girls should be treated differently. (38.7% from Lohardaga and 37.3% from Gaya agreed).

IV. The following item is given individual attention as it is on inheritance which may not mean as much in tribal areas as it would be in other regions:

Item 5: Families should provide daughters with as much inheritance as sons, and as much control over the use of inherited amount. (58.4% from Lohardaga and 64.3% from Gaya agreed).

V. There was very little or negligible variation between the two districts for the following items. These show a trend towards equality of men and women:

Item 3: Families should spend equal money on the education of daughters as on the education of sons. (84.8% from Lohardaga and 95.7% from Gaya agreed.

Item 4: Families should provide equal medical care to daughters and sons. (91.2% from Lohardaga and 97.8% from Gaya agreed).

Item 6: Men and women should have equal role in decisions about investments. (88.0% from Lohardaga and 93.5% from Gaya agreed)

Item 7: Men and women (husbands and wives) should have equal role in decisions about spending money.(89.6% from Lohardaga and 91.9% from Gaya agreed).

Item 10: Both parents should have equal say in the decision to have a child (85.6% from Lohardaga and 93.0% from Gaya agreed).

Gender differences as an issue was in village communities of both the districts studied. Men were considered superior to women. Women occupied the place of secondary status. This was accepted by not only men, but also by women.

Section 2

GENDER PERCEPTIONS OF FAMILIES AND COMMUNITIES IN NBJK - CMHD PROGRAM AREA WITH REFERENCE TO PERSONS WITH MENTAL ILLNESS

The heads of the families interviewed in the districts of Lohardaga and Gaya were asked to respond to questions on persons with mental illness in their families. The responses were analyzed in terms of the profile of the PWMI, details of illness, care-givers of PWMI, extent of sex-stereo-typing on the tasks performed by them within and outside the household, involvement of PWMI in decision making, control over assets such as land and money by PWMI and their social status with reference to marriage. The results are presented in this section.

4.2. Socio demographic profile of persons with mental illness

Table 20: Socio-demographic profile of persons with mental illness in the two districts

Sex of PWMI	Frequency	Percent
Female	84	38.18
Male	136	61.82
Age of PWMI		
16- 20 Years	31	13.64
20 – 30 Years	73	33.18
31 – 40 Years	76	34.10
41 – 50 Years	25	11.36
51 – 60 Years	14	6.36
61 and above	3	1.36
Education level of PWMI	**Frequency**	**Percent**
Illiterate	91	40.90
Primary	76	34.58
Secondary	32	14.54
Higher secondary	15	6.862
Graduation	7	3.16
Previous Occupation of PWMI		
Agriculture	74	33.64
Petty Shop / Small Business	12	5.45
Household Work	37	16.82
Salaried Job	3	1.36
Labourer	32	14.55
None	22	10.00
Studying	40	18.18

The data presented in the above table reveals that there were more males with mental illness identified than females with mental illness. The ratio of men and women identified and brought for treatment was 62:38. This formed the basis to search for the reasons for un-equal distribution of males and females having mental illness.

Though the data in the Table does not show analysis according to the districts in the two states, it was considered important to look at the variations, if any, between the districts and between the states as the tribal and non-tribal population proportions of the two districts varied. Lohardaga district had a higher proportion of tribals than in Gaya district.

Out of the total 84 female PWMI, 44 were from Lohardaga and 40 were from Gaya district. Of the total 136 male PWMI, 56 were from Lohardaga and 80 were from Gaya. The number of female PWMI was almost equal in both the districts, hence they are comparable.

The above table shows that 67.11% of the respondents were in the productive age group of 20 – 40, as the onset of mental illness was found during their late adolescence and in early adulthood period. Nearly 14% of the respondents were in the age group of 16- 20, affecting their lives quite early, especially their career paths. Only 19% of the respondents were above 40 years, for most of them have had illness for a long period. Comparing the variations between the two districts, it was found that Gaya had more PWMI in the younger age group (below 20 years) than in Lohardaga.

With regard to educational qualification of the respondents, it was found that 40% of PWMI were illiterates with almost no ability to read or write their names. Only 48.64% of PWMI had attended school, picked up basic reading and writing skills. Very few people (10.36%) had gone to high school or to college. The variations between the two districts were seen in that Gaya had a higher number of PWMI with higher secondary education, whereas Lohardaga had a lower number. In both the districts nearly one fifth of women and nearly equal percentage of males were illiterates. The female literacy percentage dropped at the primary level itself in both the districts. Though Gaya showed a higher proportion of males at the higher secondary level, in Lohardaga there were two females with higher secondary education and not even one male at that level.

Ninety percent of PWMI were involved in productive work and supporting their families, whereas 10.36% were not involved in any productive work. Among those involved in productive work, 33.33% of PWMI were involved in agriculture related activities; 14.41% of the people with severe mental illness were on coolie jobs; 16.67% of wives were able to take care of house hold activities; 1.35% of them were on government jobs with regular income; 18.47% of them were continuing their education.

4.2.1: Illness details of Persons with Mental Illness

Table 21: Details of mental illnesses of the identified persons with mental illnesses in Lohardaga and Gaya districts

Duration of illness of PWMI in years	Frequency	Percentage
0 – 5 years	110	50.00
5 - 10 years	80	36.36
10 years and above	30	13.64
Duration of Treatment of PWMI in years		
Less than 2 years	101	45.90
2 – 5 years	85	38.64
6 – 10 years	15	6.82
10 years and above	19	8.64
Types of illness of PWMI		
Severe mental illness	102	46.36
Common mental illness	118	53.64
Types of Treatment received by PWMI		
Medicine	159	72.27
Faith healer	1	0.45
Both medicine and faith healer	60	27.28
Gap between occurrence of illness and treatment		
Yes	174	79.1
No	46	20.9
Present Situation of PWMI		
Under treatment but not stable	31	14.09
Under treatment and stable	140	63.64
Stable and stopped treatment	30	13.63
Not stable but stopped treatment	19	8.64
Source of Treatment of PWMI		
RINPAS	96	43.64
Camp	119	54.09
Self arrangement	4	1.81
Other	1	0.45

The above table indicates that 50.45% of persons with severe mental illness have had the illness for more than five years, indicating its chronic nature. 50% of the respondents were having illness for less than five years. With appropriate support, this group has better chance for recovery leading to a normal and enhanced quality of life. Nearly 50% of the respondents were taking treatment since two years, 40% of them taking treatment for five years. 10% of them have been treated for more than six years, which indicates the chronic nature of the illness.

The table shows that 54% of PWMI are availing treatment from the mental health camps conducted by NBJK. 43% of PWMI were getting treatment from RINPAS. The districts varied with the source of treatment. In Lohardaga almost all PWMI were treated at RINPAS, but in Gaya majority were treated in the camps. 2.15% of PWMI arranged for mental health care on their own.

The table reveals that 53% of the people had common mental illness, and 47% had severe mental illness. The districts showed a marked variation in the proportion of PWMI with major, minor or common mental illnesses. Majority in Gaya had major mental illness and majority in Lohardaga had minor/ common mental illness and this was found especially among females.

Most persons with mental illness, i.e. 72% of them were availing treatment from the mental health camps held every month in Lohardaga and Gaya. 28% of them had faith in medicines and also in faith healing. One respondent was getting care only from a faith healer.

When we look at the pathways to mental health care, we found that 80% of the people had a gap before they came for treatment. The districts varied with Lohardaga showing all PWMI having a gap between occurrence of illness and treatment, whereas in Gaya it was about 60%.

Most of them seemed to have approached faith healers, black magician and religious places with the belief that the person was possessed by evil spirit or affected by black magic. Most of the families appeared to have spent a lot of money in this process, draining their resources before they came to mental health camps.

The districts varied with the number of PWMI treated with both medicine and faith healers. Gaya showed a higher proportion (about 40%) than Lohardaga with only nine percent. In both the districts, both males and females (about 25%) were using medicines as well as going to faith healers.

Most of the identified persons with mental illness (77.47%) were taking treatment regularly from mental health camps, in that 63.51% of them had recovered from positive symptoms and were on maintenance dose in order to prevent relapse. 14% of PWMI had stopped treatment on their own as they had recovered from the illness and reached the pre-morbid level of functioning. Around 8.56% of respondents had stopped treatment as they felt medicines were not helping them. The two districts showed variations in that Lohardaga had 89% under treatment and stable, whereas Gaya had only about 40% in the same category. Around 60% of both males and females were in this category.

4.2.2. Caring of Persons with Mental Illness

Table 22: Care-givers of persons with mental illness in Lohardaga and Gaya

Relationship of PWMI with the head of the family	Frequency	Percent
Father	18	8.18
Mother	11	4.99
Daughter	20	9.09
Son	77	35.00
Brother	30	13.64
Sister	4	1.82
Others	60	27.28
Who takes care more or always of PWMI		
Female	106	48.2
Male	68	30.9
Both	46	20.9
Who gives medicines to them		
Female	104	47.3
Male	84	38.2
Both	32	14.5

In families, 35% of sons and 9% of daughters were caring for the mentally ill parents. 8% of the father and 5% of the mother were taking care of their mentally ill children. 15% of the siblings were giving care to their mentally ill siblings. 28% of them were other relatives like spouses, aunts etc.

In most families, the female cared for the ill person at home, whereas the male contribution for caring was only 30%. In 21% of families both males and females cared for their mentally ill family member. In both the districts, both females and males were taking care of PWMI. In Lohardaga it was 49% females and 44% males and 6% of both males and females. In Gaya it was 46% of females and 20% of males and 33.3% of both males and females.

There were variations between the two districts with reference to who administers the medicines to PWMI. Lohardaga showed more males than females (53% males and 44% females and 3% of both males and females). Gaya showed 27% males, nearly 49% females and 24% of both males and females.

4.2.3: Pathways to Organization (NBJK) for seeking Mental Health Care

Table 23: Pathways to contact organization (NBJK) for initiating care for persons with mental illness

	Frequency	Percent
Reasons to get to the organization		
Easy reach	32	14.5
Free treatment	103	46.8
Suggested by relatives and friends	39	17.7
Suggested by health worker	5	2.3
Failure of previous treatment	33	15
Other reasons	8	3.6
Source of information about organization		
From the staff of the organization	179	81.4
From friends and relatives	41	18.6

Forty seven percent of the respondents continued to have contact with the organization (NBJK) as they were getting free treatment; 14% found it easy to approach the organization; 15% approached the NGO as the previous treatment was not helpful. Only 2.3% of them were referred by the health worker to approach the organization for availing free treatment.

4.2.4: Involvement of Persons with mental illness in household chores

Table 24: Household chores carried out by persons with mental illness

Household chores carried out by persons with mental illness	Yes	Percent	No	Percent
Waking up first	9	4.1	211	95.9
Going to bed last	6	2.7	214	97.3

About 97% of persons with mental illness did not wake up first or went to bed last in order to do household chores and to take care of family members.

Table 25: Involvement of persons with mental illness in caring for the elderly and children in the family

Chores carried out	Yes	Percent	No	Percent
Taking care of elderly	13	5.9	207	94.1
Taking care of children	58	26.4	162	73.6
Getting their children ready for school	24	10.9	196	89.1
Guiding their children in their studies	17	7.7	203	92.3

Sex-wise involvement of persons with mental illness in caring for the elderly and children in the family

Chores carried out	Yes		No	
	F	M	F	M
Taking care of the elderly	3	9	81	127
Taking care of children	23	35	61	101
Getting their children ready for school	16	8	68	128
Guiding their children in their studies	5	12	79	124

A small percent (about 6%) of PWMI took the responsibility of caring for the elderly. Out of these, more males (4%) than females (1.4%) were given this task. The districts varied in that Lohardaga had 9% of PWMI (2% females and 7% males) with this responsibility, whereas in Gaya, only 2.5% (0.83% females and 1.66% males) were involved in this.

A higher percentage (26%) of PWMI was involved in taking care of their children. Here again, more male PWMI were involved in this task than females (15.90% males and 10.45% females). The two districts varied in that Lohardaga had 51% of PWMI involved in this activity, whereas only 5.8% of PWMI from Gaya district were carrying out this task. This may be due to the number of PWMI with minor mental illness was higher in Lohardaga. In both districts, higher numbers of males were involved. In Lohardaga about 20% of females were taking this responsibility, whereas in Gaya it was only 2.5%.

A total of about 11% of PWMI were involved in the task of getting the children ready for school. More females (7.3%) than males (3.6%) were doing this task. Here again the districts varied with Lohardaga showing 12% of female PWMI taking up this chore, whereas in Gaya it was 3.3% of females. Only a small percentage (7.7%) of PWMI were guiding the children in their studies, more males (5.45%) doing this than females (2.27%). The districts varied as in Lohardaga a total of 10% were helping with this task (4% females and 6% males), but in Gaya only 0.8% of females and 5% of males were involved in this task.

Table 26: Involvement of persons with mental illness in daily household chores

Household Chores	Yes	Percent	No	Percent
Cleaning the house	67	30.5	153	69.5
Cooking food	49	22.3	171	77.7
Cleaning utensils	59	26.8	161	73.2
Washing clothes	62	28.2	158	71.8
Fetching water	96	43.6	124	56.4
Gathering fuel	55	25	165	75.0
Repairing the house	63	28.6	157	71.4

Sex-wise involvement of persons with mental illness in daily household chores

Household chores	Yes		No	
	Female	Male	Female	Male
Cleaning the house	54	13	30	123
Cooking food	44	5	40	131
Cleaning utensils	52	7	32	129
Washing clothes	44	16	40	120
Fetching water	51	45	33	91
Gathering fuel	19	36	65	100
Repairing the house	8	55	76	81

From the above table it is evident that around 30% of PWMI were involved in household tasks like cleaning the house, cleaning utensils and clothes. Almost 44% were involved in fetching water, 25% helped in gathering firewood, and 22% of them helped in cooking food for the children.

The two districts varied in the male-female PWMI helping in the tasks mentioned here. In Lohardaga 52% (40% females and 12% males) of PWMI were involved in cleaning the house and in Gaya it was only 12.5% (11.6% females and 0.83% males). In cooking food, Lohardaga had 31% (27% females and 4% males), whereas Gaya had 8.2% (7.7% females and 0.8% Males). In cleaning utensils, Lohardaga had 41% (35% females and 6% males) of PWMI and in Gaya, it was 15% (14.2% females and 0.8% males). In washing clothes, Lohardaga showed 38% of PWMI (30% females and 8% males) were involved, whereas in Gaya it was 10.0% of PWMI (6.4% females 3.6% males).

The tasks of gathering fuel and attending to the repairs in the house were seen essentially as male tasks even with PWMI. A total of 25% of PWMI (8.63% females and 16.36% males) were helping in gathering fuel. In Lohardaga, about a third, 33% (13% females and 20% males) were involved in fuel gathering, whereas in Gaya it was 18.3% of PWMI (5% females and 13.3% males). In attending to repairs in the house, a total of 28.6% of PWMI (3.6% females and 25% males) were involved. In the two districts studied the percentage of PWMI involved in this task varied. In Lohardaga, 47% of PWMI (3% females and 44% males were doing this task whereas in Gaya, it was 13.3% (4.1% females and 9.2% of males).

4.2.5: Involvement of Persons with mental Illness in agricultural activities:

Table 27: Involvement of persons with mental illness in agricultural activities

Agricultural Activities	Yes	Percent	No	Percent
Taking care of cattle	117	53.2	103	46.5
Taking care of agriculture	38	17.3	182	82.7
Plough the land	64	29.9	156	70.1
Sowing seeds	15	6.8	205	93.2
Watering plants	70	31.8	150	68.2
Weeding	13	5.9	207	94.1
Harvesting /cutting the yield	77	35.0	143	65.0
Selling/marketing the produce	12	5.5	208	94.5
Engaging in Income Generation Activities	177	80.5	43	19.5

Sex-wise involvement of persons with mental illness in agricultural activities

Agricultural Activities	Yes		No	
	Female	Male	Female	Male
Taking care of cattle	41	76	43	60
Taking care of agriculture	7	31	77	105
Plough the land	2	62	82	74
Sowing seeds	2	13	82	123
Watering plants	15	55	69	81
Weeding	2	11	82	125
Harvesting/cutting the yield	44	33	40	133
Selling/marketing agricultural produce	0	9	84	127

The above table indicates that more than half of PWMI were involved in taking care of the cattle. More males (34.5%) than females (18.6%) were doing this task. Districts varied in terms of PWMI doing this job. Lohardaga had 81% and Gaya had only 15.5% in this category. This may again be due to a larger number of PWMI in Lohardaga having minor mental illness.

In contrast to caring for cattle, very small percentages of PWMI (17.3%) were helping with agricultural work. Among them more males (14.1%) than females (3.2%) were taking up this work. The districts of Lohardaga (18%) and Gaya (16.6%) did not show much variation in participation of PWMI in this task. In both the districts the female participation was also lower than the male.

Taking the various agricultural tasks individually, namely, ploughing the land, sowing seeds, watering plants and weeding, PWMI participation was low in sowing seeds (about 7%) and weeding (about 6%) as compared to ploughing the land (30%) and watering plants (about 32%). In all these tasks the female PWMI participation was lower than the male. Males were ploughing (28%), sowing seeds (6%), watering the plants (25%) and weeding (5%), whereas

women PWMI were ploughing (1%), sowing seeds (1%), watering plants (7%) and weeding (1%).

People with mental illness were hardly involved in either selling or buying agricultural products. On most occasions, it was either their parents or siblings who took this responsibility. Only 4% males were engaged in this task (96% of PWMI were not involved). Between the two districts Lohardaga showed three PWMI (one female and two males) and Gaya had 9 PWMI (one female and 8 males). People with mental illness hardly had any control over the resources. As marketing involves money, transactions were not entrusted with PWMI.

Majority of the families seemed to have the desire that their mentally ill members should occupy themselves in productive activities and contribute to the family income. Women with mental illness were expected to take up responsibility of household chores and help in agricultural activities. The families expected men with mental illness to be involved in agricultural activities and in coolie work. Families were encouraging men with mental illness to be involved in income generation activities apart from doing their regular work.

4.2.6: Decision making

Table 28: Involvement of persons with mental illness in the decision making process in the family

Participation of PWMI in family decision making		
	Frequency	Percent
Always	47	21.4
Sometimes	60	26.8
Never	113	51.9
Total	220	100.0

Sex-wise PWMI participation in family decision making		
	Male	Female
Always	30	17
Sometimes	41	19
Never	65	48

The data presented show that persons with mental illness participated in family decision making, 21.4% always participating, 52% participating sometimes, and about 27% never participated in this process. These could be with severe mental illness. More males (30%) were involved in family decision making than females (21%). The districts varied in that 4% (male 2% female 2%) in Lohardaga were never involved in decision making, whereas in Gaya nearly 46% (32% male and 14% female) were not at all involved in family decision making.

Table 29: Family support for their mentally ill member for accessing money as a resource and also deciding on spending it

Activities	Yes	Percent	No	Percent
Families give money to PWMI to spend	178	81	42	19
People with mental illness can decide how to spend the given money	151	70.3	69	31.3

The above given frequencies show that 81% of the families are giving money for medical treatment and other personal expenses of persons with mental illness. The above table also indicates that 70.3% of PWMI (41% males and 27.7% females) could decide on how their money can be spent. The districts varied with reference to this variable. Lohardaga showed a rather high percentage (95%; 42% female and 53% male) of PWMI taking decisions on how to spend the money given, whereas in Gaya it was much lower, only 46% with 16% females and 30% males. As the quantum of money is not specified, it is not clear as to how much money they were given and what kind of decisions they took about spending it.

4.2.7: Control over the assets by persons with mental illness

Table 30: Persons with mental illness having control over assets

Property ownership of persons with mental illness		
	Frequency	Percent
Have property in their name	70	31.8
Do not have property in their name	150	68.2
Total	**220**	**100.0**

Sex-wise distribution of property ownership of persons with mental illness		
	Male	Female
Have property in their name	52	18
Do not have property in their name	84	66

The above table indicates that only about 32% of persons with mental illness owned property and 68% did not own. Even with 70 persons with mental illness who owned property, it was their parents, sibling and their children who had control over the assets. In Lohardaga 45% of PWMI owned property (12% females and 33% males), and in Gaya only 21% of PWMI owned property, 16% males and 5% females.

Table 31: Family members managing the property of PWMI

Family members	Frequency	Percent
Father	26	11.8
Mother	9	4.1
Son	10	4.5
Brother	11	5.0
Others	14	6.4
Not applicable	150	68.2
Total	**220**	**100.0**

4.2.8: Persons with mental illness and marriage

To understand how mental illness affects leading a social life within the community, the respondents were asked "Has there been or will there be any problem in your family while considering marriage for a man or a woman with mental illness? The results are presented below.

	Frequency	Percent
Affected	188	85.4
Not affected	27	12.3
Not applicable	5	2.3
Total	**220**	**100**
Sex-wise distribution of PWMI affected in their married life due to mental illness		
	Male	**Female**
Affected	117	70
Not Affected	19	9
Not applicable	0	5
Total	**136**	**84**

The above table shows out that mental illness did affect getting suitable alliance for the marriage of person with mental illness. This was reported in 86% of those in their marriageable age, which indicates the stigma associated with mental illness. Generally in communities, a person with mental illness is perceived as someone not capable of taking care of him or herself and of others dependent on him / her. This has affected the male and female equally.

Table 33: Families finding an alliance for marriage of women with mental illness as a problem

	Frequency	Percent
Yes	32	15.0
No	52	23.6
Not applicable	136	61.4
Total	**220**	**100**

Out of 75 women with mental illness, 33 women had difficulty to get an alliance for their marriage. Forty two women with mental illness were able to get an alliance and it is possible that in most of these cases they may not have disclosed the status of their illness at the time of marriage.

Table 34: Families finding alliance for siblings of PWMI as a problem

	Frequency	Percent
Yes	63	28.6
No	74	33.6
Not applicable	83	37.8
Total	**220**	**100**

The above table shows that nearly 29% of the families found difficulties in getting alliance for their children because of the presence of mentally ill family members. About 34% of the families did not find it a problem in getting alliance for their siblings.

Table 35: Mental illness affecting women's married life

	Frequency	Percent
Yes	197	89.6
No	17	7.7
Not Applicable	6	2.7
Total	**220**	**100**

The above table indicates that a majority (about 90%) reported that women's married life get affected by mental illness. Probably they are deserted by their husbands.

While discussing with the community, Maheshwari Devi said, "Anyone affected by mental illness will face problem in getting married. But women suffer more as compared to men. Men with mental illness have little more acceptance than women with mental illness. But it is true that there would be problem after marriage."

To add to it, Kalawati Devi said, "There is a lot of stigma in the community regarding this illness. So everyone avoids such people. When a man is affected with mental illness he is less likely to get deserted by his family, especially by his wife. But this is not so with women with mental illness. In almost all instances men desert their mentally ill wives and remarry.

CHAPTER 4 : MAJOR FINDINGS AND RECOMMENDATIONS

Community development is essentially people's development and people's determination to improve the quality of their lives. The process of development is complex. It is not merely helping people to increase their income or providing some extra gadgets or technology to reduce the burden of their work. Development, in the true sense, is helping people to look at their **belief system**, the expressions of which either facilitate or hinder their development, which in turn could bring changes in the people involsved and changes in the quality of their lives. For this to happen, those engaged in development work need to understand the belief system of people with whom they are working.

One important aspect of the **belief system** in any community is its **gender perspective.** Gender is a social concept, a distinction between men and women introduced by families and communities as a set of rules and expectations that govern the behavior of boys and girls, men and women. There may be variations in the rules and expectations of different sections of a community.

Gender is seen as an **issue** when the distinction between men and women in communities is governed by rules and expectations that create a hierarchy, places one over the other and affect their lives adversely.

The present study is an effort at gaining a perspective on **'gender'** in the **Community Mental Health and Development Program** areas of Nav Bharat Jagriti Kendra through a sample study of the communities in Bhandra Block in Lohardaga district in Jharkhand, and Paraiya block of Gaya district of Bihar state. The purpose of the study was to find the reasons for wide variations found in the number of men and women seeking treatment in the Community Mental Health Program of BNI and NBJK implemented in those regions.

Profile of families participating in the study

A general profile of the families in the community is presented here as a background information for understanding the findings on the 'Community Gender Perspective '

A total of 220 families (with a person with mental illness), 100 from Lohardaga district of Jharkhand and 120 from Gaya district of Bihar participated in the study. Majority of the families (195) were **male headed** and only 25 families were **female headed.** The families are essentially patriarchal. **Caste-wise,** most of the families belonged to Scheduled Castes (20%), Scheduled Tribes (25%) and Backward castes (42%). **Religion-wise,** majority were Hindus (70%). Interestingly, one fifth of the families (20%) belonged to **'Sarna'** religion, prevalent among tribal community, worshippers of nature, which is not an officially recognized religion. Taking the **economic condition** of the families, majority (80%) were poor (Below the Poverty Line). In most of the families one to three members were engaged in livelihood activities. Participation of female in livelihood /income-earning activities was high among tribal groups (96%), Schedules Castes (89%), other castes (59%); among 'Sarna' religious group (96%), Hindus and Muslims (67%); among non-literates (33%) and semi-literates (38%); among low income families depending on agriculture (79%) and coolie work (82%).

Profile of the Participants (Heads of the Families with a mentally ill person)

Majorities were males (195) and only 25 were females (20 from Gaya district and five from Lohardaga district). They were predominantly middle-aged (77%), mostly non-literates or semi-literates (69%), majority farmers (74%) and another 20% coolies or involved in petty business. A few held jobs, one lawyer and two religious priests.

Section I A: Gender Perceptions of Families and Communities in the Program Area

Generally, families and communities specify tasks to be performed by men and by women. Though it could be understood as division of labour or sharing of responsibilities by different members of the family and community, caution is necessary in accepting this line of thinking, as it could also be seen exclusively as men's tasks and women's tasks; categorized as heavy or light tasks; more important and less important tasks; house-hold tasks and outside tasks. These kinds of categorization bring in the elements of discrimination such as heavy, important and outside tasks are men's tasks; light, less important and household tasks are women's tasks. When this hierarchy is introduced, the power in terms of right of ownership of and control over resources is with men, who occupy the primary status in the hierarchy. Thus the family relations between men and women in the family become power relations. Biological distinction between men and women can thus become social discrimination between them.

In the present study, efforts have been made to study

- Tasks performed by men and women within the household and outside;
- Involvement of men and women in decision making in the family in general; decisions on spending money, specific decisions regarding number of children to have, right of women to visit the doctor; planning for limiting the family size;
- Access to and control over resources with special reference to ownership of house, land, cattle and vehicles within the family.
- Social status of men and women with reference to the preference for male child, celebration of male/female child-birth, educating boys and girls, interaction between adolescent boys and girls, age for marriage, practice of giving or taking dowry, importance given to marital status.
- Gender –role perceptions in terms of agreeing / disagreeing to 19 statements which were considered to be the general beliefs regarding the male and female roles.

The major findings with regard to gender perceptions of families and communities on each of these different aspects are presented here. The emerging picture is the 'gender perspective' of the two districts studied.

1. Tasks performed by men and women within the house-hold

In general, almost all the house-hold tasks were reported to be performed by women. The tasks such as waking up first in the morning (74% female), going to bed last (80% female), taking care and preparing children for school (66% female), fetching water (87% female), cooking food (98% female), cleaning the house (97% female), cleaning the utensils (98% female) and washing clothes (90% female) were essentially reported to be done by a large percentage of women.

Hence they could be considered as **female tasks**. All these tasks are **reproductive tasks** confined to house-hold where women had the major responsibility for them. Within the household, tasks such as taking care of the elderly (7% male,28% female and 30% both male and female), looking after the study of children (57% male and 26% female and 7% both male and female), gathering fuel (36% male, 31% female and 32% both male and female) and taking care of cattle (15% male, 11% female and 55% both male and female) were carried out by both men and women. It is interesting that taking care of children was the woman's task. But, looking after the study of children was more of a male task. Since gathering fuel and taking care of the cattle both require going out of the household, men were taking some responsibility to play this role as **boundaries of movement outside the home for women are restricted.** Repairing the house was seen as a man's task (75% male). This again is a task considered **heavy** and only men can carry this out.

The study showed variations among castes with reference to the task of 'taking care of the elderly' in that both males and females shared in general caste whereas it was much lower in other caste groups, as major proportion of these families were nuclear.

It was observed that in nuclear families males were involved in household tasks such as preparing children to school, fetching water, collecting firewood, cleaning the house, cleaning utensils and washing clothes; and females were taking such responsibilities as guiding children in studies, repairing the house and taking care of cattle. Probably in these families females were taking more responsibilities both inside and outside the home. This needs to be looked at in terms of the load of work of women.

2. Tasks performed by men and women outside the household

The tasks outside the house such as taking care of agricultural work (60% male, 3% female and 21% both), going to city market for shopping (83% male), selling agricultural products (76% male), ploughing the land (79% male), sowing seeds (67% male), watering the field (66%), weeding (81% male). All these were essentially **male** tasks. They are all considered as '**productive tasks'.** Men operate outside the house and **their movement has no restricted physical boundaries, more free.** They **controlled the production process and hence the valuable resources of land, water, cattle and money.** The tasks such as harvesting the yield (13% male, 30% female and 41% both) and shopping in local village market (45% male, 20% female and 35% both) were carried out by both men and women. It was also found that women from higher income families and general caste were involved mostly in household chores, whereas women from lower income families, from lower caste groups and from nuclear families were involved in household as well as outside activities playing a supportive role to men.

The **Gender perspective** that emerges is that there is **sex-stereo-typing** and **hierarchy** in the kinds of tasks performed by men and women with men in **productive tasks** with control of resources and women in **reproductive tasks.** The status of women is definitely secondary.

3. Decision making in the family

In general, it was found that families participating in the study tended to discuss with other family members before taking any major decisions concerning the family (96% in male headed

families and 76% in female headed families). It appears that consultation with other family members was much more in secure families with regular and high income. Though majority of families (90%) reported about women's participation in family meetings, involvement of women in decision making process was much higher among tribal communities (98%), compared to other castes (90%), among Christian and 'sarna' followers and among members of the nuclear families. It is an **interesting finding** that though men consulted women, the final decision was taken mostly by men (61%). Joint decision-making was reported by only 15% of the families. Females took the final decisions in 15% of the families only.

The power of final decision making rested mostly with men. There were very little response variations with reference to caste, religion, education and livelihood activities. Small variations were observed in favour of women in families that were nuclear and with a higher income.

Decision-making regarding the finances in the family – how the money to be spent – was made by men in one half of the families; by joint decision of men and women in one third of the families, and by women in one fifth of the families.

When asked about spending the small money women saved, they spent much of their savings in meeting the needs of their children such as buying books, pencils, clothes and sweets; meeting health needs and treatment and on emergencies arising in the family.

Women seemed to spend their savings mostly on family needs and very little on themselves. Even among female headed families, only 50% of females made decisions, the rest reported a joint decision. More women taking decisions on spending money was found in religious groups of 'Sarna' and Christians, in families with a higher education and in nuclear families with lower income, probably because they were also earning members.

Decision on the number of children to have was reported to be a joint decision of men and women in 60% of families; female decision in 15% of families and male decision in 25% of families! Higher the educational level, higher and more regular the income level, higher was the joint decision making. Among Muslims no woman was reported to take decision on the number of children she should have. **Though child bearing is the responsibility of women, it is interesting that men seemed to have more part in taking a decision on the number of children. This points to a situation in which women's control over one's own body was with others.**

Regarding **surgical intervention for family planning,** majority reported that it should be undertaken by women rather than men. About 56% women and only 5% men had surgical intervention. Practicing family planning is a taboo among the Muslim community. The reasons given for women rather than men should have the surgery were that the surgery would make men weak and they cannot afford to rest. This view was held not only by men but women too justified the same. This was evident in the qualitative data collected in the Focus Group Discussions.

It was brought out that women were free to visit a doctor (93%). But they took prior permission from men of the family (father, son, brother, husband) in 80% of the cases. **This again points to the restricted boundaries of operation for women.**

The Gender perspective that emerges with reference to decision making in general, regarding finances and in specific areas of concern of women showed that men were found to be more powerful than women as most of the important decisions in the family including those that concern women were with men. Women had less power compared to men.

4. Access to and control over resources in the family

This section deals with the physical resources of the family such as the house, land, cattle, vehicles and money in terms of bank accounts.

The **ownership of the house** was mainly with men (80%). Joint ownership was mentioned by one per cent; women owning the house was reported by 18%. Women were owners under four life situations (a) ownership transferred to wife after the death of her husband (7%); (b) when the male member was mentally ill (3%); (c) when the house was constructed under a government scheme for women (6%); and (d) when a male member made female member the owner of the property. Women ownership was more common in women headed families and also in agriculture and daily labour groups of families. **A small percentage of women getting ownership of the house under the government scheme for women is valuable as it is meeting the strategic need of women to ensure equity in gender relations** as it can help women feel a sense of self-worth and also give them an opportunity to develop the capacity to take responsibility of ownership.

The **ownership of land** again was mostly with men. Of the 172 families owning land, men had the land in their names in 139 families (81%) and women had it in their names in 24 families (4%). The reasons for female ownership of land were similar to that of house ownership.

The **ownership of cattle** was again mostly with men (71%). About 20% women reported owning the cattle. A small percentage (9%) seemed to accept joint ownership of cattle.

Major reasons given for men ownership were that men could go out of the village for buying and selling cattle which women could not; women did not have knowledge of cattle and men had the capacity to assess the quality of the cattle. Those who accepted women as owners seemed to have taken into account women's responsibility in taking care of the cattle. Here again it is evident that **women's boundaries were limited and had restricted mobility hence they carry the load of caring for the cattle.**

The **ownership of vehicles** being the prerogative of men further reiterates the restricted mobility of women. Of the 220 families, 149 families (68%) owned two wheelers, out of which 148 (99%) belonged to men. Only in 17 families both men and women used bi-cycles but the ownership was with men. Only one woman owned and used the bi-cycle herself. It is clear once again that **restricting women's mobility is glaring. Her place is home.**

With reference to the **ownership of money as a resource,** only 53% of families had bank accounts. Out of these, nearly one third had joint account of husband and wife as they felt it would increase the habit of saving in both; and wife could withdraw money when needed. In another one third of the families men were the account holders, the reason being men were earning and women were considered not capable of handling bank transactions. In 17 families (15%) women had bank accounts, as they were Self-Help-Group members; and in three families women had accounts as the male in the family had mental illness. **It is evident that**

access to and control over money as a resource was more with men than with women. Forming women SHGs and making it mandatory for women to have a bank account is a step in meeting the strategic needs of women. When seen in rights perspective this definitely can help in ensuring equity in gender relations.

The gender perspective that emerges from the findings presented in this section bring to the fore the superiority of men and the primary status given to them. Gender is an issue in these communities.

5. Social Status of men and women in the family

With reference to the birth of the child in the family, **preference for the male child** was very high (90%). The reasons given were that sons will take care of the parents, they will carry their generation forward, they can get dowry. A small percentage did not prefer daughter as she would leave parental home. The birth of a male child was reported to be **celebrated** by a little over half of the participants. Only one percent celebrated the birth of a daughter.

Perceptions regarding the **education of boys and girls** showed that they were for education of both boys and girls as it was reported by 91% that children, irrespective of their sex attended schools. About 75% said that they would spend on the education of both boys and girls and only about 19% said that they would spend more on boy's education. Both boys and girls dropped out of school; girls dropped out to support in the household work and the boys to support in the economic activities.

Interaction between adolescent boys and girls was not allowed by 52% of families. The rest allowed interactions. Among the religious groups, over half of the Hindus, two-fifths of 'Sarnas' and about a third of Christians did not allow interactions between boys and girls. Educational level of the heads of the families affected their perception in this regard. With increase in the educational level, there was increase in the percentage of heads of families perceiving the need for allowing interactions between boys and girls.

The **prevalence of early marriage** was studied. The marriage age for boys was reported to be 18-23 years by 84% of the participants. The same age range was reported for girls only by 66%. About a third of the families were of the view that girls should be married early, by 10 to 17 years of age. Child marriage practices were prevalent among SCs (56%), among OBCs (39%), general caste (19%) and STs (9%). Religion, education and income of the families did not have influence on the prevailing early marriage practices.

The reasons for the low prevalence of child marriages among Tribal communities were (a) women were bread earners; (b) custom of boys paying dowry to girl's fathers was in practise and this delayed marriages.

Marital status was given importance by the communities studied. **Both men and women when they were unmarried were looked down.** More than one half of the respondents did not want to give any response regarding unmarried status. Nearly a fifth of the participants said that women faced lots of criticism and humiliation and they were even labeled as characterless.

Giving and taking dowry was found to be a common practice. About 60% said that they would give dowry, another 11% would be willing to give and 30% would not give.

Two families said that dowry is girl's right as they do not have right over parental property. The reasons stated were that it is a tradition (29%); without dowry it is not possible to get married, dowry is necessary to get a good life partner and also for the girl to be treated with dignity at her in-law's place (50%). In 6% of the families they could not afford to pay dowry. In 47 families of the tribal community dowry (bride-price) was not a tradition.

When **preference for taking dowry** was asked, more than half of the families reported that they preferred to take dowry at the marriage of their boys. The reasons given were (a) meeting the expenses incurred by the groom's party; (b) following the tradition of giving and taking dowry. In tribal communities taking dowry for the boys was not prevalent. Caste-wise analysis showed high prevalence of giving dowry among OBCs (84%), general caste (70%) and SCs (60%). Similar pattern was seen with receiving dowry, showing some small variations - OBCs (75%), general caste (67%), SCs (64%). Religion-wise analysis showed a high prevalence of system of dowry among Muslim community (100%), Hindus (71%) and it was non-existent among Christian and 'Sarna' religious groups.

The gender perspective that emerges from the data given in this section show that in the communities studied **women occupied a low social status and men occupied a high social status.** This is evident from the male child preference, celebration of the birth of the boy, preference for early marriages for girls, looking down upon unmarried especially the women, and keeping up the tradition of taking dowry for their boys and giving dowry for their girls. The only area in which there is some kind of gender equality is in the families sending both boys and girls to school and both boys and girls dropped out of school.

Section I B: Gender-Role Perceptions of communities in the program area

A. Sex-wise analyses of responses of the participants

A total of 310 respondents (151 males and 159 females) in the villages in the study area expressed their opinion regarding the roles of males and females (gender-roles) in their community. They responded to 19 statements which were considered to be the general beliefs regarding the male and female roles in the community. Major findings are:

- The **predominant male roles** expressed by majority of males and females bring out clearly the **productive role of men and the primary status accorded to men by both men and women.** Almost an equal number of men and women expressed that (a) Men should have primary responsibility for contributing to family income (73% men and 81% women); (b) Women should consider husbands as God (74% men and 72% women); (c) Men are more capable than women for strong work (77% men and 74% women); (d) Men should have authority in the family (74% males and 81% females).

- The **predominant female roles** expressed by majority of both men and women bring out **women's reproductive role and their secondary status.** More women than men agreed that (a) Women should have primary responsibility for child care (59% males and 75% females); (b) Women should work at home and men should work outside (66% males and 80% females).

- **Male dominance and female subservience** were brought out by almost equal number of males and females, indicating **women accepting their subservient status.** The expressions of such roles were: (a) Virginity is more desirable in a woman than in a man (62%males and 64% females); (b) Men's disloyalty to wife is acceptable (20%males and 64% females); (c) Women have more medical problems than men (58% males and 75% females); (d) Men are always better at making decisions about money (55%males and 59% females); (e) Men are more rational than women (46% males and 63% females); (f) Boys and Girls should be treated differently (26% males and 46% females).

- **Equality of men and women** were accepted by over 90% of men and women in the areas of (a) sharing household work; (b) spending equal amount of money on the education of daughters and sons; (c) provision of equal medical care for sons and daughters; (d) both men and women to have equal role in decisions about investments; about spending money; (e) both parents to decide on having a child; (f) daughters to have inheritance right and authority over inherited amount (54% males and 69% females). It is interesting to see here some thinking by both men and women in the direction of equity in gender relations. It was found that this was mainly due to the variations between the two districts of Lohardaga and Gaya showing variations in their responses to statements.

B. District-wise analyses of responses of the participants

Of the 310 respondents, 125 were from Lohardaga and 185 were from Gaya. It is quite revealing to find that the responses of the participants in agreeing with statements reflecting gender-roles showed that gender as an issue (male dominance and female subservience) was more severe in Gaya district than in Lohardaga.

- Wide variations between districts were observed with reference to gender roles of (a) Sharing of responsibilities equally by both men and women in household work such as cooking, cleaning the house and washing clothes (67% from Lohardaga and 37% from Gaya); (b) Women to have primary responsibility for child care (43% from Lohardaga and 83% from Gaya); (c) Men considered more capable than women for strong work (61 % from Lohardaga and 85% from Gaya); (d) Men should have authority in the family (65% from Lohardaga and 87% from Gaya).

- Some variations between districts were found in the perceptions of gender-roles such as (a) Men should have the primary responsibility for contributing to family income (70% from Lohardaga and 82% from Gaya); (b) Men are always better at making decisions about money (50% from Lohardaga and 61% from Gaya); (c) Virginity is more desirable in a woman than in a man (54% from Lohardaga and 68% from Gaya); (d) Women should work at home and men should work outside (68% from Lohardaga and 77% from Gaya); (e) Men are more rational than women (52% from Lohardaga and 56% from Gaya). Here again though male dominance was indicated in both districts, it is more severe in Gaya than in Lohardaga.

- A small variation between districts was seen regarding gender-roles such as (a) Women should consider husbands as God (73% from both districts); (b) Men's disloyalty to wife is acceptable (about 30% from both districts); (c) Boys and girls should be treated differently (39% from Lohardaga and 37% from Gaya). Male dominance is indicated whether the percentages are low or high.

- There appears to be awareness in both the districts for demanding inheritance rights for daughters as much as for sons (58% from Lohardaga and 64% from Gaya). High percentage of respondents from both the districts agreed on gender roles such as spending equal amount of money on education of sons and daughters; providing equal medical care to sons and daughters; men and women deciding together on family investments and on spending money; both parents to have equal voice in having a child.

Considering the responses, on the whole, it could be said that **Gender is an issue in both districts though the issue is severe in Gaya than in Lohardaga.** There appears to be some awareness regarding the need for a more equitable gender relation at least for the younger generation. This is evident in the items expressed in the last paragraph above. A beginning may have been visualized. But the practices, as presented in various aspects of family life seemed to show that gender relations between men and women in the families and communities of the program area are far from equitable. It was not only men but women too subscribe to male dominance and female subservience.

Section 2: Gender Perceptions of Families with reference to Persons with Mental Illness in the Program Area

1. Socio-demographic profile of Persons with Mental Illness (PWMI)

Family heads of the Families having a PWMI participated in the study. The information on PWMI were given by them. There were 136 male PWMI (62%) and 84 female PWMI (38%) in the 220 families studied. The ratio of men and women identified and brought for treatment was 62:38, indicating a wide variation between men and women PWMI seeking treatment. Majority (67%) belonged to the age group of 20 to 40 years – in the productive age group. About 75% were non-literates or semi-literates with primary education. Very few had high school or college education (10%). About 90 % were involved in some work, mostly agriculture and related activities/ labour and were supporting their families.

2. Details of Mental Illnesses

One half of PWMI (50%) had the illness for more than five years, and another half had the illness for less than five years. Nearly 50% were under treatment for two years. 40% were under treatment for five years and 10% had been treated for over six years. About 54% were availing treatment in the mental health camps conducted by NBJK and 43% from RINPAS. About 80% had a gap before they came for treatment. Most of them seemed to have approached faith healers, black magician and religious places as there was a general belief that PWMI were possessed by evil spirit. Out of the identified PWMI, 77% were very regular in taking treatment and 64% of them recovered from positive symptoms and were on maintenance dose.

3. Care-givers of People with Mental Illness

Almost all the family members, both male and female took care of their mentally ill persons and daughters took care of their mentally ill parents; parents were caring for their mentally ill children; siblings were taking care of their mentally ill siblings and other relatives, spouses cared for their mentally ill partners. Majority of care-givers were reported to be females.

4. **Pathways to NBJK for seeking mental health care**

Free treatment attracted 47% of PWMI to NBJK; 14% because of easy reach to NBJK and another 15% came as the earlier treatment taken elsewhere did not help. Only 2% came referred by a health worker.

Gender Perceptions

1. **Tasks performed by PWMI within the household**

Not all PWMI were carrying out household tasks, as only about a third (30%) were involved in it. Even among PWMI, the tasks such as cleaning the house (24% females and 6% males); cleaning utensils (24% females and 3% males); washing clothes (20% females and 7% males); fetching water (23% females and 21% males); Cooking food (20% females and 2% males); getting the children ready for school (8% females and 4% males) were done more by females than males.

Some of the household tasks done more by male PWMI than female PWMI include taking care of the elderly (4% males and 2% females); taking care of children (16 % males and 10 % females); guiding children in their studies (6% males and 2% females) and repairing the house (25% males and 4% females).

Thus the household tasks performed by PWMI were gendered. There is sex-stereo-typing in favour of women. This brings out the actuality that woman's place is at home.

2. **Tasks performed outside the household**

Most of the tasks performed outside the household were male tasks, even with PWMI. More than one half of PWMI (35% males and 19% females) were involved in taking care of the cattle. Only 17% of PWMI (14% male and 3% females) were helping with agricultural work. About a third (29%) was carrying out tasks such as ploughing (28% males and 1% females); watering plants (25% males and 7% females); sowing seeds (6% males and 1% females); weeding (5% males and 1% females).

Only in the task of harvesting the agricultural yield, a higher percentage of female PWMI (20% females and 15% males) were involved. PWMI were hardly involved in marketing.

The tasks outside the household performed by PWMI were also gendered. There is sex-stereo-typing in favour of men. Man's place is in the community, outside the household.

3. **Decision Making within the family**

It was reported that about a fifth of PWMI (14% males and 8% of females) always participated in family decision-making. Slightly over one fourth of PWMI (19% males and 9% females) participated sometimes. Slightly over one half (52%) of PWMI (30% males and 22% females) were never involved in family decision making. Probably they were affected by major mental illnesses.

4. **Family support to PWMI**

Majority of the families (81%) provided for the medical expenses as well for other personal expenses of PWMI. They themselves could decide on how to spend the money (48% males and 28% females). As the quantum of money to be spent was not specified, it was not clear how much money was given and what kind of decisions were made by them.

5. **Control over assets of PWMI**

About a third of PWMI (a total of 32%, 24% males and 8% females) owned property, but control over the asset was with their parents/siblings and children/spouses.

6. **Social status of PWMI**

Married life of majority of PWMI (86%) was affected because of mental illness, which indicates the stigma attached to it. It was reported that 38% of girls with mental illness had difficulty in getting an alliance for their marriage, whereas 62% of girls were able to get an alliance. It is likely that the illness was not disclosed prior to marriage.

The presence of mentally ill person in a family posed difficulty in finding an alliance for others at marriageable age in the family (29%). Majority (90%) reported that women's married life get affected by mental illness. Most women with mental illness were deserted by their husbands.

The 'gender perspective' that emerges from the findings is that the primary status of men and secondary status of women are established whether they are well or ill.

Ownership of assets though reported for PWMI, the control was with other family members. In the community, PWMI held a low status in general and it was more so with women with mental illness.

District profiles of PWMI

It was found that the districts studied varied with reference to the findings on profiles of PWMI and also gender perceptions of the families. It was thought that it could be useful in taking actions at the field level.

Profile of PWMI from Lohardaga district of Jharkhand state

Of the total of 84 female PWMI, **44 (52%)** and of the total of 136 male PWMI **56 (41%)** were from Lohardaga. Though the number of males were higher than females, the variation was meager. The male-female ratio was 56:44. The number of women seeking mental health care was somewhat nearer to the number of men seeking mental health care.

Majority were in the productive age group, and most were non-literates or semi-literates. The percent of female literacy drops at primary level in the district. Interestingly there were two females with higher secondary education. Majority were involved in productive work such as agricultural / labour activities.

Majority in Lohardaga **(84%) both males and females** had **minor or common mental illnesses.** They were availing treatment from the mental health camps of NBJK. A gap between

occurrence of illness and treatment was reported by all in Lohardaga. Only nine percent were treated with both medicines and faith healers. Quite a high percentage of PWMI (89%) were under treatment and stable. Care-giving to PWMI was given by 49% females, 44% males and 6% of both males and females. Administering medicines to PWMI was mostly done by males (53%), by females (44%), only 3% by both males and females.

Gender Perceptions

1. **Household chores carried out by PWMI**

   In general, in Lohardaga district a higher percentage of PWMI (compared to Gaya district) were involved in household chores probably because of the higher proportion of PWMI had common mental illnesses.

   In the household tasks such as cleaning the house 52% of PWMI (40% females and 12% males); cooking food 31% (27% females and 4% males); cleaning utensils 41% (35% females and 6% males); washing clothes 38% (30% females and 8% males) fetching water 69% (38% females and 31% males); getting children ready for school 20% (12% females and 8% males) were taking responsibility. The figures indicate these were essentially female tasks even with PWMI.

   About 10% of PWMI were reported to be involved in tasks such as taking care of the elderly 9% (7%males and 2% females); taking care of children 51% (31% males and 20% females); guiding children in studies 10% (6% males and 4% females). It is evident that in caring for elders and children more male than female PWMI were involved. The task of gathering fuel 33% (20% males and 13% females) and repairing the house 47% (44% males and 3% females) were again more of male's tasks than females'.

   The **gender perspective** that emerges show that though there is sex-stereo-typing of tasks performed within the household, there was some sharing of responsibilities between men and women.

2. **Tasks performed by PWMI outside the household**

   In agricultural activities, 50% of PWMI (48% males and 2% females) were ploughing the land; 58% of PWMI (43% males and 15% females) were watering the plants; and 53% of PWMI (16% males and 37% females) were harvesting the crop yields. Very few were involved in sowing seeds and weeding. PWMI did not market the agricultural products.

3. **Decision making within the family**

   In Lohardaga, only 4% of PWMI (2% males and 2% females) were not involved in family decision making. A rather high (95%) of PWMI (53% males and 42% females) were taking decisions on spending the money given to them.

4. **Control over assets by PWMI**

   In Lohardaga 45% PWMI (33% males and 12% females) owned property. However, the properties owned by them were either managed by parents, siblings, children or spouses.

1. **Profile of PWMI from Gaya District of Bihar State**

   Of the total of 84 female PWMI, 41 (48%), and of the total of 136 male PWMI 79 (59%) were from Gaya. The number of males is much higher than females. This shows that the number of women seeking mental health care was much lower than the number of men

seeking the same care. Gaya had a larger number of PWMI between 16 and 20 years (42% out of which 28% had major mental illness and 14% had minor mental illness). More number, mostly males, was found to have high school and higher secondary education. Majority were non-literates and semi-literates with female literacy dropping at the primary level itself.

Majority in Gaya (70%) had major mental illnesses, and they were availing treatment from the mental health camps conducted by NBJK. Gap between occurrence of illness and treatment was reported in 60% of cases in the district. About 40% reported that they took medicines and also went to faith healers. The proportion was quite high. Only 40% PWMI were under treatment and stable. Care-giving to PWMI was done by 46% females, 20% males and 33% both males and females. Administering medicines to PWMI was the responsibility taken more by females (49%), by males (27%), and (24%). By both males and females.

2. Household chores performed by PWMI

In general, in Gaya district, a small percentage of PWMI were involved in household chores, probably because a higher proportion of PWMI had major mental illnesses.

In the household tasks such as 'cleaning the house' it was about 13% (12% females and 1% males); 'cooking food' 8% (7% females and 1% males); 'cleaning utensils' 15% (14% females and 1% males); 'washing clothes' 18% (12% females and 6% males); getting the children ready for school 3% all females.

Other household tasks such as 'taking care of the elderly' 2.5% (1.5% male and 1% female); 'taking care of children '6% (3.5% males and 2.5% females); 'guiding the children in their studies' 6% (5% males and 1% females) showed more male involvement than of female. But it should be noted in these tasks the percentage less compared with Lohardaga districts. In fetching water 23% PWMI (12% males and 11% females); in 'gathering fuel' 18% of PWMI (13% males and 5% females); and in 'attending to repairs of the house' 13% of PWMI (9% males and 4% females) were carrying out the tasks. These tasks were essentially male tasks even with PWMI.

3. Decision making within the family

In Gaya district, 46% of PWMI (32% males and 14% females) were not at all involved in the family decision making. Again only 46% of PWMI (30% males and 16% females) were taking decisions on spending the money given to them.

4. Control over assets by PWMI

Only 21% of PWMI (16% males and 5% females) in Gaya district owned property. As in Lohardaga, here too the property of the PWMI was managed by other family members, fathers, siblings, children and spouses.

Though in both districts gender is an issue, Gaya showed a higher degree of the same. As this district had a higher percentage of PWMI with major mental illnesses, their participation in tasks within and outside the household was a small percentage. Again with decision-making, Lohardaga showed higher percentage for both men and women. With access to and control over resources, both districts showed a similar pattern.

Study Highlights

The study in the NBJK's Community Mental Health and Development Program (CMHD) area of the districts of Lohardaga and Gaya clearly indicated

1. The tasks within and outside the household are largely gendered; showing that the place of women is home and the place of men is in the community. This implies limited boundaries of operation and restricted mobility for women. Moreover, the women's tasks were mostly 'reproductive tasks' and men's tasks were 'productive tasks' which implies a hierarchy of tasks as primary and secondary and takes women to an inferior status.
2. Final decision making within the family rests with men even in matters concerning women such as freedom to visit a doctor, number of children she should have and surgical intervention for family planning. This implies the superior position of men with the power that is gained from decision making, thus giving an authority for men over women.
3. Control over resources are mostly with men. Ownership of valuable resources such as house, land, cattle and vehicles are with men and hence the control is with men. Women may have access to the house, land and cattle as they work in the household, land and with cattle taking responsibilities, but the control is not with them as important decisions are made only by the owners. Again, men's primary position and women's secondary position get well established.
4. Socially, it was found that the tradition of male child preference, celebration of the birth of the male child, child marriage practices especially for girls, restricted interactions among adolescent boys and girls, accordance of a low status for the unmarried, practice of system of dowry or bride-price are observed to be very much in vogue indicating a dominant position for men and a subservient position for women, a higher social status for men and a lower social status for women.

Some variations of importance in gender perceptions among certain sub-groups or sub-samples of the total sample of the study were observed. They are:

1. Between the two districts, there were visible variations in proportion of men and women seeking mental health care; sharing of responsibilities in household task and in household decision making, with Lohardaga district showing more positive gender perceptions than Gaya district.
2. Women from high income families and general caste (upper caste) were involved mostly in household chores; whereas from lower income nuclear families and caste groups such as SCs and STs, women were involved both in household and outside activities in support of men, probably taking a high load of responsibilities.
3. In nuclear families (more among lower castes) there was some participation of men in household chores.
4. The involvement of women in decision making was much higher among tribal communities, among Christians and 'Sarna' religious groups. In Muslim communities no woman was reported to take any decision on the number of children she should have.
5. The prevailing belief that women rather than men should undergo family planning surgery was held not only by men but by women as well.

6. SHG membership and special Government schemes for women seemed to have given a better position for women in terms of house ownership and opening of bank accounts in their names. This was found in a small percentage in the program area.
7. Among tribal communities, child marriages and dowry were uncommon.

All these findings have important implications for gender equity promotion in the program area.

RECOMMENDATIONS

The following recommendations are made keeping in mind the highlights of the study and for taking action at three levels:

I. At the level of Basic Needs India (BNI) and Nav Bharat Jagriti Kendra (NBJK) it is recommended that

1. BNI and NBJK together should review the Community Mental Health and Development (CMHD) Program plan and incorporate gender components in the modules such as 'Capacity Building', 'Livelihood activities'; 'Monitoring and Documentation".
2. In 'Capacity Building' module, gender is to be in-built into the process in terms of raising awareness on gender in relationship to mental illnesses; social origins of gender; gender analyses in general and with particular reference to CMHD program.
3. In 'livelihood activities', NBJK should pay attention to sex-stereo-typing and to make efforts to bring in gender equity as far as possible.
4. NBJK besides facilitating formation of Self-Help Groups (SHGs) which are inclusive of mentally challenged, it should also enable Women SHGs to become aware of their rights as women in general and also as mentally challenged.
5. BNI to ensure that the tools of monitoring and evaluation to have sex-differentiated information so that gender can be kept in focus while deriving learning from the information collected about the impact of the program on women separately from its impact on men. The quarterly and annual reports should give information separately on men and women in the program.
6. BNI and NBJK should share the findings and recommendations of the study with their NGO partners.

II. At the level of NGO Partners

7. Each NGO partner to review their office and field staffing pattern and their recruitment criteria paying special attention to recruit and sustain men and women in almost equal proportion.
8. A series of gender sensitization camps be organized for the staff to understand the social origins of gender inequality and related issues.
9. Gender analyses (systematic way of looking at different impacts of development program on women and men) workshops be conducted to come to grips with the dominance and

subservience of men/women in terms of sex-stereo-typing of tasks performed at home and outside, power of decision-making within the family, access to and control over resources and the effect of these on women's and men's status. The data from this study could be used as a base for such an analysis.

10. As there are indications of area variations such as between districts, between tribal and non-tribal communities, planning and implementing gender sensitization programs be de-centralized - having more intensive program for those communities where the gender inequality is marked and having such programs to bring in positive gender perceptions of the communities where there is a sort of gender equity is observed.

11. As Government Schemes for women (e.g. Housing scheme giving ownership of the house and bank account in their names) seemed to bring women into focus and give them a status, it is recommended that NGO partners put their energies to help women to avail these schemes. This is to ensure personal security and legal rights of women which are different from attending to their basic needs especially reducing the burden of their work as in the case of provision of water supply, provision of gas as fuel, use of electric grinders etc., (though these are also important to have)

III. At the field level (In communities)

12. As the study indicates clearly that women themselves accept their secondary status, it is important to have special participatory gender sensitization program for women wherein opportunities are provided for them to take a look at their own life situations and reflect on them to recognize within themselves that both men and women are socialized to think and feel the way they do, and it is not by nature that they are different.

13. Mass awareness programs conducted in the field could focus on gender and mental health and gender inequality in communities and their effects on the quality of life of men and women. Such programmes through street plays, movies, stories, songs etc can facilitate the community members to analyse the situation focusing on gender as a base and its impact on the lives of men and women.

Annexure 1

Interviewing the Head of the Family of PWMI

Questionnaire No | | | | | Area Code | |

1 – Lohardaga, 2 – Paraiya

1. Individual Information

1) Name of the person:
2) Age:
3) Sex: 1 – Male / 2 – Female
4) Caste: 1 – SC / 2 – ST / 3 – OBC / 4 – GEN
5) Religion: 1 – Hindu / 2 – Muslim / 3 – Christian / 4 – Sarna / 5 – Other .....
6) Educational Qualification: 1 – Illiterate/ 2 – Primary / 3 – Secondary / 4 - Higher Secondary / 5 – Intermediate / 6 – Graduate / 7 – Professional Degree / 8 – Other .....

   a. Main Livelihood:

   b. Secondary livelihood:

7) Monthly Income (Approx)

2. Family Information

1) Type of family: 1 – Nuclear / 2 – Joint / 3 – Extended
2) Number of family members

   a. Adult Male.... Adult Female .... Adult Total.....

   b. Minor male...minor female.....minor total.....

3) Total no of people who are involved in livelihood / income generation activities..... male.....female.....

3. Mental Health

Sl	Name of PWMI	Age	Sex (A)	Relationship with family head (B)	Type of Illnesses (C)	Duration of illness	Present Situation of PWMI (D)	Source of Treatment (E)	Duration of treatment so far in months	Previous Occupation of PWMI (prior to illness)	Educational Qualification of PWMI (F)	Type of Treatment received (G)

A. 1 – Female 2 – Male
B. 1 – Father, 2 – Mother, 3 – Daughter, 4 – Son, 5 – Brother, 6 – Sister, 7 – Others
C. 1 – Major, 2 – Minor
D. 1 – Identified and not under treatment, 2 – Under treatment and not stable, 3 – Under treatment and stable, 4 – Stable and stopped treatment, 5 – Unstable but stopped treatment
E. 1 – RINPAS, 2 – Health Camp, 3 – Self, 4 – Others
F. 1 – Illiterate/ 2 – Primary / 3 – Secondary / 4 - Higher Secondary / 5 – Intermediate / 6 – Graduate / 7 – Professional Degree / 8 – Other
G. 1 – Counselling, 2 – Medication, 3 – Faith healer, 4 – Other

1. Is there a gap (loss of time) between occurrence of illness and treatment? 1 – Y/ 2 – N If yes, then why
2. Who takes care more / always of PWMI? 1 – Male / 2 – Female / 3 – Both
3. Who feeds medicines to them? 1 – Male / 2 – Female / 3 – Both
4. When the illness first started, what did you do to get help for PWMI?
5. Reasons made you to go to the organization [1 - Accessible in terms of travel to it, 2 - Free treatment, 3 - Friend / neighbour recommended, 4 - Health centre staff recommended, 5 - Failure of earlier treatment / service, 6 - No other services available, 7 - Other .....]
6. How did you find out about the organization? [1 - A field worker came and told us about the service, 2 - Local health centre mentioned the service / referred, 3 - A neighbour / friend told us about it, 4 – Other]
7. In what way the service helped PWMI and the family?

4. Household Tasks

Task	1 – Male , 2 – Female, 3 – Both, 4 – Nobody, 5 – Other	PWMI [Tick only]
Who takes care of the elderly		
Who wakes up first		
Who goes to bed last		
Who takes care of children		
Who gets children ready for school		
Who guides their study		
Who fetches water		
Who cooks food		
Who gathers fuel (firewood, coal, any other)		
Who cleans the house		
Who cleans utensil		
Who repairs the house		
Who washes clothes		

5. Tasks outside the house

Task	1 – Male , 2 – Female, 3 – Both 4 – Nobody, 5 – Other	PWMI [Tick only]
Who takes care of cattle		
Who takes care of agricultural work		
Who goes out to village market to buy daily vegetable / grocery or small household things		
Who goes out to cities for marketing		
Who sells/ markets the agricultural / other produce		
Who ploughs the field		
Who sows the seed		
Who does watering		
Who does weeding		
Who does cutting / yielding		
Who sells the crops		

6. Decision making

1)

A) Do the members of the family meet before taking a major decision on an issue? 1-Y/ 2–N

B) Do women participate in these discussions? 1 – Yes / 2 – No

C) Does the PWMI participate in the decision making process? 1 – Always / 2 – Sometimes / 3 – Never

D) Who takes the final decision? 1 – Male / 2 – Female / 3 - Both

2) Who decides how many children the family need? 1 – Male / 2 – Female / 3 Both

3) Has anybody undergone family planning operation? 1 – Husband / 2 – Wife Why

4)

(A) Is a woman of the family free to visit Doctor whenever she feels the need? 1 – Y /2 – N

(B) Does she require permission? 1 – Y / 2 – N

(C) From whom? (1 – Father, 2 – Mother, 3 – Daughter, 4 – Son, 5 – Brother, 6 – Sister, 7 – Others)

(D) Is the woman with mental illness in your family receiving regular treatment? 1 – Y / 2 – N

(E) If No, please state the reason

5) How does the women member of the family spend the small amount of money she has kept aside?

7. Social and Political status

1) Are adolescent boys and girls allowed to talk to each other? 1 – Y / 2 – N

2) What is the general age of marriage of boys?

3) What is the general age of marriage of girls?

4) Will you pay / Have you paid dowry at the time of getting your daughter/ sister / any other female member of the family, married? 1 – Y / 2 – N / 3 – May be If yes / may be, Why

5) Will you pay / Have you paid dowry at the time of getting your son/ brother / any other male member of the family, married? 1 – Y / 2 – N / 3 – May be If yes / may be, Why

6) Does the community look down upon an unmarried (above 40 years)

   a. Man? 1 – Y / 2 – N
   b. Woman? 1 – Y / 2 – N
   c. How (explain)

7) When you plan for a child, do you prefer? 1 – boy / 2 – girl? Why

8) Do you celebrate the birth of 1 – boy / 2 – girl / 3 – both? Why

9) If any women in you house wants to start any shop/ enterprise/ income generation activity or even go for job, then what would be your reaction?

10)

   A) Has there been a problem in your family, while considering marriage for man with mental illness? 1 – Yes /2 – No Explain

   B) Has there been a problem in your family, while considering marriage for woman with mental illness? 1 – Yes /2 – No Explain

11)

   A) Does Mental illness affect / has mental illness affected the marriage life of man with mental illness? 1 – Yes /2 – No Explain

   B) Does Mental illness affect / has mental illness affected the marriage life of woman with mental illness? 1 – Yes /2 – No Explain:

12) Do you promote the PWMI in you family to involve in income generation activities? 1 – Yes /2 – No

8. Education

1. Do you think it is as important to educate girls as educating boys? 1 – Yes /2 – No
2. Do both boys and girls go to schools? 1 – Yes /2 – No

3. Did any of the children dropped out of school? 1 – Yes /2 – No
If yes, who and why?

4. On whose education do you spend more money? 1 – Boy child's / 2 – girl child's / 3 – Spent same amount?

9. Access to and control of resources

1) Who keeps money in the house? 1 – Male / 2 – Female / 3 – Both

A) Who decides how the money would be spent? 1 – Male / 2 – Female / 3 – Both

2) Do you give any money to the PWMI in your family to spent? 1 – Yes /2 – No

A) 2.1. Can he / she decides how to spend the money? 1 – Yes /2 – No

3) Do you have a house? 1 – Yes /2 – No

a. If yes, who owns the house? 1 – Male / 2 – Female / 3 – Both

b. Why ?

4) Do you have a piece of land? 1 – Yes /2 – No

a. If yes, who owns the house? 1 – Male / 2 – Female / 3 – Both

b. Why?

5) Do you have cows / bulls/ goats / any other pet animal? 1 – Yes /2 – No

a. If yes, who owns those? 1 – Male / 2 – Female / 3 – Both

b. Who takes care those cattle? 1 – Male / 2 – Female / 3 – Both

c. Who sells and buys those cattle? 1 – Male / 2 – Female / 3 – Both

d. Why?

6) Do you have cycles/ motor cycles/ scooters? 1 – Yes /2 – No

a. If yes, who owns them? 1 – Male / 2 – Female / 3 – Both

b. Why?

7) Do the family have an account in Bank / Post Office? 1 – Yes /2 – No

a. If, yes, then who holds the account? 1 – Male / 2 – Female / 3 – Both

b. Why?

8)

a. Does the person with mental illness have property in his/her name?

b. If yes, who takes care of it? (1 – Father, 2 – Mother, 3 – Daughter, 4 – Son, 5 – Brother, 6 – Sister, 7 – Others)

Annexure 1

Prompts for Focused Group Discussion

FGD – (Male and Female Group)

1. What is the main occupation of the community
2. Do female members help male members in that?
3. Is there any school nearby
4. Do boys outnumber girls in that school
5. Is there any medical facility available nearby
6. When does women access that / how often / on what circumstances (pregnancy / serious illness / minor illness)
7. When does men access that / how often
8. Is there a difference then why
9. Is there anybody with mental illness in the village
10. Is he/she under treatment
11. Is that person stabilized
12. Do people stay with him/her
13. Is the life of a women with mental illness different from a male with mental illness
14. Do family members act quickly for male with mental illness than female with mental illness
15. Do women have SHGs in the village
16. What do they do
17. Do SHGs take developmental activities or just involved in credit and thrift activities?
18. Does the girl child get equal right as the boy child on property of family?

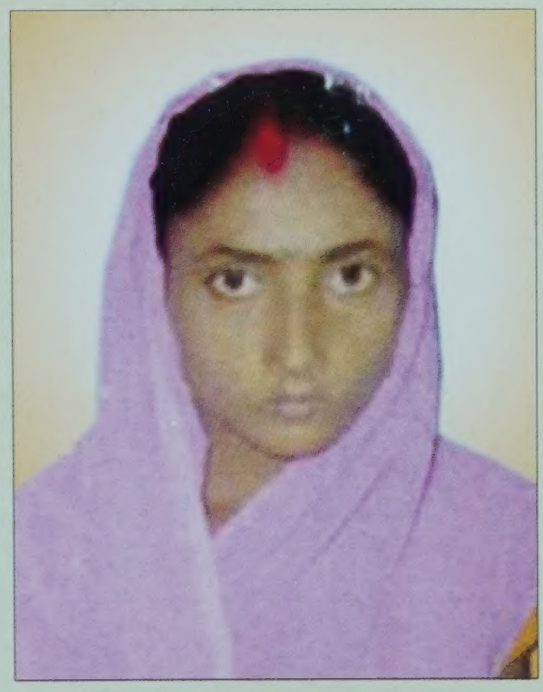
Especially for FGD – female group

19. Do they take loan from SHGs
20. For what purpose they use the loan
21. Have they ever taken loan for some business / enterprise
22. Who owns that business / enterprise
23. Who does marketing of the products
24. Who buys raw materials
25. Who fixes prices

Annexure 2

FGD (Disagree / agree) Questionnaire

1. Husbands and wives should share equally in housework such as cooking, washing dishes, and housecleaning. (agree or disagree)
2. The husband should have primary responsibility for contributing to the family income. (agree or disagree)
3. Families should spend equal money on the education of daughters as on the education of sons. (agree or disagree)
4. Families should provide equal medical care to daughters and sons. (agree or disagree)
5. Families should provide daughters with as much inheritance as sons, and as much authority over the use of inherited amount. (agree or disagree)
6. Men and women (Husbands and wives) should have equal role in decisions about investments. (agree or disagree)
7. Men and women (Husbands and wives) should have equal role in decisions about spending money. (agree or disagree)
8. Virginity is more desirable in a woman than in a man. (agree or disagree)
9. Men's disloyalty to wife is acceptable (agree or disagree)
10. Both parents should have equal say in the decision to have a child. (agree or disagree)
11. Women (wives) should have primary responsibility for child care. (agree or disagree)
12. Women (wives) should consider husbands (men) as god. (agree or disagree)
13. It is believed that women should work at home and men should work outside of the home. (agree or disagree)
14. Men are more capable than women for strong work. (agree or disagree)
15. Women have more medical problems than men. (agree or disagree)
16. Men are always better at making decisions about money. (agree or disagree)
17. Men should have authority in the family. (agree or disagree)
18. Men are more rational than women. (agree or disagree)
19. Boys and girls should be treated differently. (agree or disagree)



Life stand for living

Nirma Devi

Village Bishunpur, Chandi Block, Nalanda

Nirma has studied up to class seven. She did domestic work and kept few goats earlier but started to complain "kuchho kare ke man na kra hai laga hai ki dinbhar sutal rahi" *(Do not feel like doing anything as I feel very sleepy all the time).* She is living with her father, mother and two younger brothers. Her elder brother is a truck driver and the younger one is studying. The family is dependent on agriculture with three bigha land (1.8 acres) on which they grow wheat and paddy.

Nirma was married to a man from a nearby village but his family sent her back to her parents after they found out about her mental illness.

Before her illness Nirma did all domestic work like cooking food, taking care of cattle and other agriculture works. According to Ramkali Devi, her mother – when she and Nirma went to 'usur' (paddy mill) one day, she complained of headache and wanted to sleep. After some time she did not speak nor respond to any question. Such behaviour continued for several days and she also started to behave strangely. She was taken to a local doctor and given some medicines but it did not help.

Ramkali Devi heard about the medical camps of NBJK and took her there. She is now receiving treatment and getting medicines from the camp. In last two years Nirma has improved greatly and there is some significant change as she takes her medicines regularly. Now she is able to do domestic work. Some times there is some relapse so her mother gets worried. With these changes Nirma's husband is willing to take her back. Nirma too is interested to go back to him.

Ramkali Devi and Nirma Devi are bold. They had many problems but they faced them bravely. The mother played a significant role in Nirma's improvement. Both of them have faith in the treatment they got and are willing to make adjustments in their life.

Case Study by Vijay Chandra
Kasturba Gramin Vikas Parisad (Partner of NBJK)
Chandi, Nalanda

If by strength is meant brute strength then, indeed woman is less brute than man. If by strength is meant moral power, then woman is immeasurably man's superior. Has she not greater intuition, is she not more self sacrificing, has she not greater powers of endurance, has she not greater courage ? without her, man could not be"

"Men and women need to be educated equally in housework because the home belongs to both"

"Subjugation and exploitation of woman was the product of man's interested teachings and women's acceptance of them."

- Mahatma Gandhi